

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3481 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03449

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 3 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. STREET ADDRESS 118 Harrison St.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First William	Middle Earl	Last Arble
4. DATE OF DEATH April 25 1956	Month April	Day 25	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 12-1897
9. AGE (In years last birthday) 58	10. IF UNDER 1 YEAR Months 58 yrs.	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter & Paper hanger		10b. KIND OF BUSINESS OR INDUSTRY Self	
11. BIRTHPLACE (State or foreign country) Thornton, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jarusia Vandergrift		14. MOTHER'S MAIDEN NAME Ellen Arble	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. Mrs. Joseph Vandergrift, Cumberland, Md.	
17. INFORMANT Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 975X (b) drowning DUE TO (c)	
		INTERVAL BETWEEN ONSET AND DEATH about	
		5 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) River.	
20c. TIME OF INJURY Month, Day, Year 4.15 p.m. April 25 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Potomac river		20f. (City or town) Cumberland	
		(County) Allegany	
		(State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		DATE SIGNED April 26-1956	
ACTUAL SIGNATURE H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 27, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Allegany County Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.		24a. REC'D BY REGISTRAR April 27, 1956	
ADDRESS Kight		24b. REGISTRAR'S SIGNATURE W.L. Frantz, M.D.	

EXAMINER'S CERTIFICATE OF DATA
FEDERAL BUREAU OF INVESTIGATION - U. S. DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION
APR 30 1956

03450

3482

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. LENGTH OF STAY IN 1b 1 hr.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY W. Va.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mineral			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		d. STREET ADDRESS Ridgeley		d. STREET ADDRESS 40 Third Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Robert		First	Middle	Last	4. DATE OF DEATH Baker	Month	Day	Year					
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 21, 1901		9. AGE (In years last birthday) 55 yrs.	10. IF UNDER 1 YEAR Months 5 Days 5 Hours 0 Min. 0		11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintainance man		10b. KIND OF BUSINESS OR INDUSTRY Fort Cumb. Hotel		11. BIRTHPLACE (State or foreign country) Hendricks, W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Robert J. Baker		14. MOTHER'S MAIDEN NAME Sarah V. Carr		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes, 1918-1921		16. SOCIAL SECURITY NO. 214-07-3020		17. INFORMANT Mrs. Evelyn Baker		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO <i>Acute Coronary Occlusion</i>		INTERVAL BETWEEN ONSET AND DEATH 1 hour	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Phil		(County) 133 Virginia Ave	(State) Cumberland, Md.
21. I certify that I attended the deceased from July , 19 54 to Phil , 19 56 , that I last saw the deceased alive on April 16 , 19 56 , and that death occurred at 12:15 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 133 Virginia Ave, Cumberland, Md.		ACTUAL SIGNATURE G. Overton Himmelwright, M.D.		DATE SIGNED 4/16/56							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/56		22c. NAME OF CEMETERY OR CREMATORIUM Fort Ashby Cemetery		22d. LOCATION (City, town, or county) Fort Ashby, W. Va.		(State) W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland		24a. REC'D BY REGISTRAR April 18, 1956		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.							

STATE OF SOUTH DAKOTA
CERTIFICATE OF DEATH

STATE

BUREAU V. S.

APR 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03451

CERTIFICATE OF DEATH

3537

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport rural		c. LENGTH OF STAY IN 1b 80 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport rural	
d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) James	First	Middle	Lost
4. DATE OF DEATH	Month April	Day 3	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 21, 1873
9. AGE (In years lost birthday) 62 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Track-man		10b. KIND OF BUSINESS OR INDUSTRY Coal mine	
10c. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Barnard		14. MOTHER'S MAIDEN NAME Mary C. Smiley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. —	
17. INFORMANT		Address Mrs. James W. Barnard-Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerosis		4 Days	
DUE TO (c)		10 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour a.m. p.m.	Month 19	Day	Year
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Piedmont, W. Va.		(County) (State)	
21. I certify that I attended the deceased from Feb 15, 1956, to Apr 3, 1956, that I last saw the deceased alive on Apr. 1, 1956, and that death occurred at 4:10 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul R. Wilson		ADDRESS (Street, city or town, state) Piedmont, W. Va.	
PHYSICIAN'S NAME (Type) Paul R. Wilson		DATE SIGNED 4-6-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/6/56	22c. NAME OF CEMETERY OR CREMATORIAL Philos Cem.	22d. LOCATION (City, town, or county) Westernport
23. FUNERAL DIRECTOR'S SIGNATURE E. Bival - Westernport, Md.		24a. REC'D BY REGISTRAR DATE 4-6-56	24b. REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly

RECEIVED

BU EAU V. S

APR 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3538 CERTIFICATE OF DEATH

03452

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b Lifetime		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		d. STREET ADDRESS 7 East Main St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital				d. STREET ADDRESS 7 East Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Elizabeth		First	Middle	Lost	4. DATE OF DEATH April	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	B. DATE OF BIRTH Dec. 23, 1873	9. AGE (in years lost birthday) 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Dress Women's Shop		11. BIRTHPLACE (State or foreign country) Frostburg		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Bath		14. MOTHER'S MAIDEN NAME Elizabeth Warne						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-05-7092		17. INFORMANT Mrs. Harry Beall		1. BROADWAY Address Frostburg, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Uremia		DUE TO (b) Cardiovascular Renal Disease		DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 442X						3 months		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from January , 19 56 to 4/23 , 19 56 , that I last saw the deceased alive on 4/22 , 19 56 , and that death occurred at 7 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 48 Broadway, Frostburg, Md.		
ACTUAL SIGNATURE Hilda Jane Walters						DATE SIGNED 4/23/56		
PHYSICIAN'S NAME (Type) Hilda Jane Walters, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-25-56		22c. NAME OF CEMETERY OR CREMATORIAL Frostburg Memorial Park		22d. LOCATION (City, town, or county) Frostburg		
23. FUNERAL DIRECTOR'S SIGNATURE Deutsch & Montesont		ADDRESS Hafer Funeral Home 23 E. Main, Frostburg, Md.		24a. REC'D BY REGISTRAR 4-26-56		24b. REGISTRAR'S SIGNATURE See Nancy N. Roe		

TO HOSPITAL OR ATTENDANT: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

18

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 1 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3483 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03453

Reg. Dist. No. 4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with Farm PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u>		b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		d. STREET ADDRESS <u>122 Independence St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in-hospital, give street address) <u>D.O.A. at the Sacred Heart Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alvin</u>		First	Middle <u>Richard</u>	Last <u>Beavers</u>	4. DATE OF DEATH Month <u>April</u>	Day <u>30</u>	Year <u>1956</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 24-1902</u>	9. AGE (in years last birthday) <u>53</u>	10. IF UNDER 1 YEAR Months <u>0</u>	11. IF UNDER 24 HRS. Days <u>0</u>	12. IF UNDER 24 HRS. Hours <u>0</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Vendor Operator -for Maryland</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Workshop for the Blind</u>		11. BIRTHPLACE (State or foreign country) <u>Sterling, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ralph Beaver</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Reeves</u>		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-30-6842 (wife)</u>		17. INFORMANT <u>Clara Beavers, Cumberland, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5870</u> DUE TO <u>Peritonitis</u> about Conditions, if any, which goe rise to immediate cause (a), stating the underlying cause last. (b) DUE TO <u>Ruptured gallbladder</u> (c) DUE TO <u>Acute pancreatitis</u>	
						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		22. MEDICAL CERTIFICATION					
ACTUAL SIGNATURE <u>H. V. Denning M.D.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>H. V. Denning M.D.</u>		DATE SIGNED <u>April 30, 1956</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORIAL <u>Queen's Point Cemetery</u>		22d. LOCATION (City, town, or county) <u>Keyser, West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Silcox Funeral Home, Cumberland, Maryland.</u>		24a. REC'D BY REGISTRAR <u>May 1, 1956</u>					
		24b. REGISTRAR'S SIGNATURE <u>W.R. Frantz, M.D.</u>					

BUREAU A. S.

MAY 3 1956

REGEVIE

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3484

CERTIFICATE OF DEATH

Reg. Dist.

03454

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE PENNSYLVANIA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CRUMP NURSING HOME		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TURTLE CREEK	
3. NAME OF DECEASED (Type or print) AUGUSTUS		d. STREET ADDRESS	
4. DATE OF DEATH APRIL 9 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-19-1901
9. AGE (In years lost birthday) 54 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired carpenter		10b. KIND OF BUSINESS OR INDUSTRY for brother-in-law	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME LOUIS BERKENBAUGH		14. MOTHER'S MAIDEN NAME EVA WYPER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 17. INFORMANT MISS EVA BERKENBAUGH, TURTLE CREEK, PA.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		19. INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 322.2		Chronic myocarditis	
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		Alcoholism	
DUE TO			
(c)		2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Apr 5 1956 to Apr 9th 1956 that I last saw the deceased alive on April 7 1956 , and that death occurred at 3:29 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 111 W. Trevaskis, St. M.D. Cumberland, Maryland	
ACTUAL SIGNATURE R. W. Trevaskis, Sr.		DATE SIGNED 4/11/56	
PHYSICIAN'S NAME (Type) R. W. TREVASKIS, SR.		CUMBERLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4-13-56	
22c. NAME OF CEMETERY OR CREMATORIAL ST. MICHAEL'S CEMETERY		22d. LOCATION (City, town, or county) FROSTBURG, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE DURST		24a. ADDRESS FROSTBURG, MD.	
24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE W. W. Tracy, M.D.	

CERTIFICATE OF DEATH

MURKIN

BUREAU V. S.

APR 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3549

CERTIFICATE OF DEATH

03455

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland		c. LENGTH OF STAY IN 1b 50 yrs		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY Allegany		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Midland															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print)		First JANE		Middle S.		4. DATE OF DEATH 4/19/1956		Month Day Year		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Sept, 9th, 1868.		9. AGE (In years lost birthday) 87 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework Own Home		11. BIRTHPLACE (State or foreign country) Scotland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Arthur Stuart						14. MOTHER'S MAIDEN NAME Mary Grey				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Congestive heart failure										INTERVAL BETWEEN ONSET AND DEATH 2 mos.															
										Several yrs.															
										Several yrs.															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)															
21. I certify that I attended the deceased from April 15, 1956 to April 19, 1956 , that I last saw the deceased alive on April 18, 1956 , and that death occurred at 8:15 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Leslie R. Miles, Jr.</i>																									
PHYSICIAN'S NAME (Type) Leslie R. Miles, Jr., M.D.																									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/22/1956		22c. NAME OF CEMETERY OR CREMATORIAL Memorial Park		22d. LOCATION (City, town, or county) Frostburg, MD.																			
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn, Lonaconing, MD.		ADDRESS		24a. REC'D BY REGISTRAR DATE 4-26-56		24b. REGISTRAR'S SIGNATURE <i>Jeanette M. Boal</i>																			

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE
APR 30 1956

BUREAU U. S.

APR 30 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3485 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH
 a. COUNTY allegany MARYLAND
 b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
 c. LENGTH OF STAY IN 1b
 d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 624 Fairview Ave

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
 a. STATE MD b. COUNTY allegany
 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
 d. STREET ADDRESS 624 Fairview Ave

3. NAME OF DECEASED (Type or print) First Anna Middle Matilda Last Bowers 4. DATE OF DEATH Month April Day 13 Year 1956

5. SEX Female 6. COLOR OR RACE white 7. MARRIED NEVER MARRIED 8. DATE OF BIRTH April 8, 1881 9. AGE (In years lost birthday) 75 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY At Home 11. BIRTHPLACE (State or foreign country) Mt Savage Md. 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George E. Aldridge 14. MOTHER'S MAIDEN NAME Mary Sterling

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 70 16. SOCIAL SECURITY NO. None 17. INFORMANT Mrs Minola Baker - 624 Fairview Ave

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebral Hemorrhage INTERVAL BETWEEN ONSET AND DEATH
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES NO

20a. MEDICAL CERTIFICATION ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
 Hour a. m. 19 20d. INJURY OCCURRED
 p. m. While Not while
 at work at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 416 N Centre St 20f. (City or town) Cumberland (County) allegany (State) Md.

21. I certify that I attended the deceased from 4/10, 1956, **to** 4/13, 1956, **that I last saw the deceased alive on** 4/12, 1956, **and that death occurred at** 6:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Dr. N. Ley Jr. M.D. **ADDRESS (Street, city or town, state)** 416 N Centre St **DATE SIGNED** 4/16/56

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial **22b. DATE THEREOF** Apr 16, 1956 **22c. NAME OF CEMETERY OR CREMATORIAL** Hillcrest Funeral Parl **22d. LOCATION (City, town, or county)** Cumberland **(State)** Md.

23. FUNERAL DIRECTOR'S SIGNATURE John G. Lakes **ADDRESS** Cumberland, Md **24a. REC'D BY REGISTRAR** W.R. Drury, M.D. **DATE** April 16, 1956

THE STATE OF HAWAII - GOVERNOR'S

8122 CERTIFICATE OF DEATH

BUREAU V. S.

APR 18 1952

REGISTRATION

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3539

CERTIFICATE OF DEATH

034579

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 8 wks.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Miners Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Mt. Savage	
d. STREET ADDRESS		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First LAURA	Middle BELLE	Last BOWMAN
4. DATE OF DEATH	Month Apr	Month 30	Day Year 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-1-1887
9. AGE (in years from birthday) 68	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John F. Friddle		14. MOTHER'S MAIDEN NAME Sarah E. Doman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 450.0		16. SOCIAL SECURITY NO. none	
17. INFORMANT John W. Bowman, Mt. Savage, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterial Sclerosis		INTERVAL BETWEEN ONSET AND DEATH 53	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. Depressive Psychoses			
(b) DUE TO			
(c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. g. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 17 , 1956, to Apr 30 , 1956, that I last saw the deceased alive on Apr 30 , 1956, and that death occurred at 4:45 PM , from the causes and on the date stated above. ACTUAL SIGNATURE John Mc Lane PHYSICIAN'S NAME (Type) John Mc Lane			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-3-56	
22c. NAME OF CEMETERY OR CREMATORIAL Methodist Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Savage, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		24a. REC'D BY REGISTRAR DATE 5-3-56	
ADDRESS		24b. REGISTRAR'S SIGNATURE Mr. Harvey A. Rose	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

FBI BUREAU

MAY 8 1956

FBI BUREAU

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3486 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03458

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 15 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural) Springfield	
3. NAME OF DECEASED (Type or print) Fred		First Louis	Middle Brinker
4. DATE OF DEATH April 25 1956	Month April	Day 25	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16-1889
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 6	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Mathias Brinker		14. MOTHER'S MAIDEN NAME Louisa Ruppenkamp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 232-60-5023 (son)	
17. INFORMANT Charles W. Brinker		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock, Intra-abdominal hemorrhage DUE TO 835X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ruptured abdominal viscus & lower DUE TO (c) portion of abdominal aorta. DUE TO INTERVAL BETWEEN ONSET AND DEATH 4 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Driving tractor up decline, upended & fell on him.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driving tractor up decline, upended & fell on him.	
20c. TIME OF INJURY Hour 3 p. m.		Month, Day, Year 4-25 1956	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) Springfield	(County) Rhode
		(State) Hampshire	(State) W.Va.
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		DATE SIGNED April 26-1956	
EXAMINER'S NAME (Type) H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 28, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Sts. Peter & Paul Cem.
22d. LOCATION (City, town, or county) Cumberland, Maryland.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpaelli, Cumberland, Maryland		24a. REC'D BY REGISTRAR April 27, 1956	24b. REGISTRAR'S SIGNATURE W.L. Frantz, M.D.
ADDRESS Scarpaelli		DATE April 27, 1956	

APR 30 MEDICAL EXAMINER CERTIFICATE OF DEATH
DEPARTMENT OF HEALTH-ENVIRONMENTAL 87

BUREAU V. S.

APR 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3550

CERTIFICATE OF DEATH

03459

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Watercliffe Street		d. STREET ADDRESS Watercliffe Street			
3. NAME OF DECEASED (Type or print) CATHERINE		First ESTHER	Middle BRODERICK		
4. DATE OF DEATH April 23	Month 1956	Day 19	Year 56		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Sept 29. 1887		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) Lonaconing, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Patrick Stakem		14. MOTHER'S MAIDEN NAME Catherine E. Cavanaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None			
17. INFORMANT William Broderick, Lonaconing, MD.		Address (HUSBAND)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 4h.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Coronary Occlusion		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.) Hypertension Cardiovascular Disease			
20c. TIME OF INJURY Hour a. m. p. m.	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D.	20f. (City or town) Lonaconing, MD.	(County) Frederick Co.	(State) Md.
21. I certify that I attended the deceased from July 19, 1957 to 23 Sept 1957 , that I last saw the deceased alive on 23 Sept 1957 , and that death occurred at 9:00 AM , from the causes and on the date stated above.					
ADDRESS (Street, city or town, state) Lonaconing, MD.					
DATE SIGNED 4-24-56					
ACTUAL SIGNATURE <i>George Eichhorn</i>		PHYSICIAN'S NAME (Type) George Eichhorn			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/26/1956	22c. NAME OF CEMETERY OR CREMATORIAL ST. Marys Cemetery.	22d. LOCATION (City, town, or county) Lonaconing, MD.		
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	24a. REC'D BY REGISTRAR DATE 4-26-56		
24b. REGISTRAR'S SIGNATURE <i>Jeanette M. Good</i>					

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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APR 26 1966

LEGEND

Within corporate limits.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-5 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3487

CERTIFICATE OF DEATH

03460

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY Allegany

CITY (If outside corporate limits, write RURAL
OR
TOWN and give nearest town)

Cumberland,

MARYLAND

LENGTH OF STAY
(in this place)
55 yrs

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

1314 LaFayette Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN Cumberland

STREET
ADDRESS

(If rural give location)

1314 LaFayette Ave

3. NAME OF DECEASED (Type or Print)

(First) William

(Middle) A.

(Last) Brown

4. DATE (Month) (Day) (Year) OF DEATH April 15 1956

5. SEX

M.

6. COLOR OR RACE

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH

March 4, 1879

9. AGE last birthday

77
yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired Boilermaker Railroad

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Dennis N. C.

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

W. F. Brown

14. MOTHER'S MAIDEN NAME

Amanda Huggins

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

NO

(Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

705-12-4634

17. INFORMANT & ADDRESS

Wife- Sally Brown 1314 LaFayette

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)
GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO
(C)

18. MEDICAL CERTIFICATION

Cirrue Myocarditis

INTERVAL BETWEEN
ONSET AND DEATH

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED While at work Not while at work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

alive on April 15, 1956, to April 15, 1956, that I last saw the deceased
and that death occurred at 6 A.M. from the causes and on the date stated above.
ADDRESS (Street, city, town, state) Cumberland, Md. 4-1628
SIGNATURE

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

DATE THEREOF

4-18-56

NAME OF CEMETERY OR CREMATORIAL

Twigg Failey Cem.

LOCATION (City, town, or county)

Near Oldtown, Md.

(State)

24. REC'D BY REGISTRAR

DATE April 17, 1956

REGISTRAR'S SIGNATURE

Winter R. Tracy, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

James F. Scarpelli

ADDRESS

Cumberland, Md.

BY THE STATE-TELEGRAMS TO THE STATE-TELEGRAMS

RECEIVED BY TELEGRAMS

RECEIVED BY TELEGRAMS

RECEIVED BY TELEGRAMS

BUREAU V.

APR 18 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3488 MEDICAL EXAMINER'S CERTIFICATE OF DEATH03461
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Bedford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. LENGTH OF STAY IN 1b 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 99 D. O. A. at the Sacred Heart Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ALICE	Middle G.	Last BRUNER
4. DATE OF DEATH	Month APRIL	Day 19,	Year 19 56
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1881
9. AGE (In years less birthday) 75 yrs.		IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Bedford Valley, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Levi Hartman	
14. MOTHER'S MAIDEN NAME Mary Smith		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mabel Growden, Bedford Valley, Penna.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion		INTERVAL BETWEEN ONSET AND DEATH Sudden	
DUE TO 420.1		?	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis		?	
DUE TO (c) Arteriosclerosis		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. V. Deming, M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED April 19, 1956
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 22, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Bethel Methodist Cem.	22d. LOCATION (City, town, or county) (State) Bedford Valley, Pennsylvania
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland.	ADDRESS	24a. REC'D BY REGISTRAR <i>April 20, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>W.R. Frantz, M.D.</i>

BUREAU V. S.

APR 23 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3489 CERTIFICATE OF DEATH

03462

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 136 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL AVE.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) MRS HAZEL		First B.	Middle BURKE
4. DATE OF DEATH APRIL 25	Month Month	Day Day	Year Year
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 12 1898
9. AGE (In years lost birthday) 55 58 yrs.		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOSEPH KRIMM	
14. MOTHER'S MAIDEN NAME BERTHA MILLER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL, CUMBERLAND MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 190X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Coronary Breast = generalized metastasis 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from March , 1954, to April 25 , 1956, that I last saw the deceased alive on April 25 , 1956, and that death occurred at 12:20 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>George M. Simons</i> M.D. 128 Union St., Cumberland 4/28/56		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) George M. Simons, M.D.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
22e. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 28, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR DATE April 28, 1956
			24b. REGISTRAR'S SIGNATURE J.R. Frantz, M.D.

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Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3490

03463

Item 8, Film g 195, 4/10/56 bh CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 10 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, MEMORIAL AVE.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) POINTS		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) XOX	First JAMES	Middle Howard	Last H. BURKETT	4. DATE OF DEATH APRIL 1 1956	Month APRIL	Day 1	Year 1956				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH AUG. 1, 1903	9. AGE (In years lost birthday) 51 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0			
8. OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME WESLEY JOHN BURKETT		14. MOTHER'S MAIDEN NAME MARY E. INSKEEP		Address MEMORIAL HOSPITAL, CUMBERLAND, MD.							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO Coronary Occlusion (c)			INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 3	Day 1956	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 3152	20f. (City or town) 471	(County) 1956	(State) 1956			
21. I certify that I attended the deceased from alive on 4/1/1956 , and that death occurred at 12:35 PM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 4526 N Centre St, Cumberland					DATE SIGNED 4/4/56				
ACTUAL SIGNATURE Leo H. Ley Jr.		PHYSICIAN'S NAME (Type) LEO H. LEY JR. MD.					22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 4, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Wesley Chapel Cemetery	22d. LOCATION (City, town, or county) Points, Hampshire Co., W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE Kirk Shaffer		ADDRESS Pennsy 4120					24a. REC'D BY REGISTRAR April 3, 1956	24b. REGISTRAR'S SIGNATURE W. H. Frantz, M.D.			

CERTIFICATE OF DEATH

APR 4 1956

YANKEE

STATE

DAY OF

YEAR

DECEASED PERSON'S NAME

NAME OF MARRIED PERSON

BUREAU V.

APR 4 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, write "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3491 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 03464

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Allegany Co. Infirmary		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Anna		4. DATE OF DEATH April 22 1956	
First Anna	Middle Marie	Last Campbell	Month Day Year April 22 1956
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15 1882
9. AGE (In years last birthday) 74		10. IF UNDER 1 YEAR Months 0	
		11. IF UNDER 24 HRS. Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Hensel		14. MOTHER'S MAIDEN NAME Catherine Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT (husband) James W. Campbell, Cumberland, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		Coronary occlusion (right) INTERVAL BETWEEN ONSET AND DEATH 10 hrs.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Cardiac hypertrophy (moderate) ?	
(b)		Hydrothorax (bilateral) ?	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Pulmonary edema ?	
(c)		Ascites ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <i>H. V. Deming M.D.</i>		DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 22-1956	
EXAMINER'S NAME (Type) H. V. Deming M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 24, 1956	
22c. NAME OF CEMETERY OR CREMATORIUM St. Luke's Lutheran Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc., Cumberland, Maryland.		24a. REC'D BY REGISTRAR April 24, 1956	
		24b. REGISTRAR'S SIGNATURE W. R. Frantz, M.D.	

DEPARTMENT OF HOMELAND SECURITY - FEDERAL BUREAU OF INVESTIGATION
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1985

BUREAU V. S.

APR 25 1985

REGEL V. FEL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3492

CERTIFICATE OF DEATH

03465

Reg. Dist. No. 7

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRESAPTON		d. STREET ADDRESS Cresap Park	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First LOLA	Middle M.	4. DATE OF DEATH	Month APRIL	Day 29	Year 1956
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 30, 1912	9. AGE (In years last birthday) 43	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W. VA. Brushy Run		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME EDGAR HEDRICK		14. MOTHER'S MAIDEN NAME PHOEBE YOKUM					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Everett W. Clem, Cresaptown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 237X		DUE TO <i>Brain Tumor (4th ventricle)</i>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last.		(b) DUE TO					
		(c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 13 days , 19 56 , to 29 Apr. , 19 56 , that I last saw the deceased alive on 29 Apr. , 19 56 , and that death occurred at 9:35 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Fuller B. Whitworth</i>				ADDRESS (Street, city or town, state) M.D.		DATE SIGNED 4/30/56	
PHYSICIAN'S NAME (Type)		Fuller B. Whitworth M.D.		Cumberland, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 2, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Bur. Park		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS		24a. REC'D BY REGISTRAR May 2, 1956		24b. REGISTRAR'S SIGNATURE W. F. Frazee, M.D.	

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U. S. BUREAU

MAY 4 1956

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MAY A 1956

3493

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland 3/27/56		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 91 Allegany County Infirmary		d. STREET ADDRESS 51 Boone Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		e. DATE OF DEATH April 29, 1956	
3. NAME OF DECEASED (Type or print) First Pauline		Middle Pearl Last Cline	
4. DATE OF DEATH April 29, 1956		Month April Doy 29 Year 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH 1/11/1926
8. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome	
11. BIRTHPLACE (State or foreign country) West Virginia (Marian County)		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Albert Phillips		14. MOTHER'S MAIDEN NAME Hazel V. Price	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-24-5596	
17. INFORMANT		Address P.O. Box 599 Allegany County Infirmary Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.9 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Peritonitis (Gen.)			
INTERVAL BETWEEN ONSET AND DEATH 2 days			
DUE TO General carcinomatosis			
INTERVAL BETWEEN ONSET AND DEATH 1 week			
DUE TO Secondary anemia v. Traution			
INTERVAL BETWEEN ONSET AND DEATH 6-12 mos.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/27/56 , 19 56 , to 4/29/56 , 19 56 , that I last saw the deceased alive on April 29 , 19 56 , and that death occurred at 8:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 49 Greene Street DATE SIGNED April 30, 1956			
ACTUAL SIGNATURE <i>James E. McLean</i>		M.D.	
PHYSICIAN'S NAME (Type) Dr. James E. McLean		Cumberland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-2-56	
22c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cem		22d. LOCATION (City, town, or county) Cumberland, Md	
23. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Scappelli</i>		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR May 2, 1956		24b. REGISTRAR'S SIGNATURE <i>W. Frank, M.D.</i>	

BUREAU V. S.

RECEIVED
12 SEPTEMBER 22 MAY 4 1956

RECEIVED

Dr. James E. Johnson

10

10

3551 CERTIFICATE OF DEATH

Reg. Dist. No. 4

I

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Cumberland	MARYLAND LENGTH OF STAY (in this place) 19 days	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS Lyric Apts.
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH April 3 1956	
(First) F	(Middle) M	(Last) Condon	AGE last birthday 79 yrs.
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) S	8. DATE OF BIRTH March 3 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Micheal Condon		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unk.) No		16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS (bro.) Joseph M. Condon, same address
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 592X IMMEDIATE CAUSE (A) <u>Chronic Valvular Heart Disease</u> INTERVAL BETWEEN ANTECEDENT CAUSE(S) DUE TO <u>General arteriosclerosis</u> ONSET AND DEATH DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (B) <u>Chronic Nephritis</u> ? STATING UNDERLYING CAUSE LAST. DUE TO <u>Female psychosis</u> ? (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21b. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>March 15, 1956</u> , to <u>April 3, 1956</u> , that I last saw the deceased alive on <u>April 2, 1956</u> , and that death occurred at <u>8:25 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Frederick J. Dean</u> M.D. ADDRESS (Street, city, town, state) <u>49 Greene St.</u> DATE SIGNED <u>4-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 4-5-1956	NAME OF CEMETERY OR CREMATORIAL St. Michael's Cemetery	LOCATION (City, town, or county) Frostburg, Md. (State)
24. REC'D BY REGISTRAR	REGISTRAR'S SIGNATURE Walter R. Durst, Md.	25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.	
DATE <u>April 5, 1956</u>	ADDRESS		

BUREAU V. S.

APR 6 1951

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03468

DR. W. F. WMS.

3494

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 25 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY MARYLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near CUMBERLAND, rural			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL						d. STREET ADDRESS BRADDOCK ROAD, R.F.D. #5				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) CHARLES		First Herman		Middle Cook		4. DATE OF DEATH APRIL 17, 1956		Month APRIL		Day 17			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 18, 1903		9. AGE (In years lost birthday) 52 yrs.		10. IF UNDER 1 YEAR Months 0		11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY B&ORR		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME JAMES H. COOK				14. MOTHER'S MAIDEN NAME MARTHA DUFFY									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-05-4982		17. INFORMANT MEMORIAL HOSPITAL		Address WARWICK & MEMORIAL AVES.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]													
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma rt lung</i> DUE TO <i>one year</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that I attended the deceased from 4/17/31 to 4/17/56 that I last saw the deceased alive on 4/17/56 , and that death occurred at 2:20 PM , from the causes and on the date stated above.													
ADDRESS (Street, city or town, state) 4788													
ACTUAL SIGNATURE <i>W. F. Williams, Cumberland</i> DATE SIGNED													
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.													
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/20/56		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)					
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox													
ADDRESS Cumberland, Md.													
24a. REC'D BY REGISTRAR April 20, 1956													
24b. REGISTRAR'S SIGNATURE <i>W. F. Tracy, M.D.</i>													

BUREAU V. S.

APR 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03469

3540

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 50 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 160 Frost Ave.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. STREET ADDRESS 160 Frost Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First WILLIAM	Middle FRANCIS	Last DAVIES
4. DATE OF DEATH April 21, 1956	Month April	Day 21	Year 1956
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED	8. DATE OF BIRTH 8-3-1866
9. AGE (In years lost birthday) 89 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired custodian	11. KIND OF BUSINESS OR INDUSTRY Lewis Apts.	12. BIRTHPLACE (State or foreign country) Cardiss, Wales
13. FATHER'S NAME Wm. Davies	14. MOTHER'S MAIDEN NAME Elizabeth Francis	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) none	
16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. James Brode, Frostburg, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH Scirndy 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. p. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Apr 21, 1956 to Apr 21, 1956 that I last saw the deceased alive on Apr 21, 1956 and that death occurred at Frostburg , from the causes and on the date stated above. ACTUAL SIGNATURE Wm. Davies PHYSICIAN'S NAME (Type) Wm. Davies			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-23-56	22c. NAME OF CEMETERY OR CREMATORIAL F'bg. Memorial Park
22d. LOCATION (City, town, or county) Frostburg, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		24a. REC'D BY REGISTRAR DATE 4-24-56	24b. REGISTRAR'S SIGNATURE Dee Dailey A. Roe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

NAME

ADDRESS

BUREAU V.

MAY 1 1956

KREGELV E D

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3552

CERTIFICATE OF DEATH

034704

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE

Maryland

b. COUNTY

Allegany

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Near Cumberland, rural

c. LENGTH OF STAY IN 1b

68 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Near Cumberland, rural

d. NAME OF HOSPITAL (If not in hospital, give street address)
OR INSTITUTION

Union Grove Road, R.F.D. #3

d. STREET ADDRESS

Union Grove Road, R.F.D. #3

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

6. COLOR OR RACE

7. MARRIED NEVER MARRIED

8. DATE OF BIRTH

9. AGE (In years
last birthday)
yrs.10. IF UNDER 1 YEAR
Months Days Hours Min.

Female

White

WIDOWED DIVORCED

Feb. 27, 1888

68

11. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Tailoress Clothing Alteration

Cumberland Md.

U.S.A.

13. FATHER'S NAME

Hunter J. Shinholz

14. MOTHER'S MAIDEN NAME

Lourissa Briggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

214-05-5965

17. INFORMANT

R. W. DeMoss Cumberland, Md.

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Coronary Occlusion

INTERVAL BETWEEN
ONSET AND DEATH

420.1

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY
PERFORMED?YES NO 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour o. p. m. 1920d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 3/31, 1956, to 4/8, 1956, that I last saw the deceased
alive on 3/31, 1956, and that death occurred at 1:35 P.M. from the causes and on the date stated above.ACTUAL
SIGNATURE

Leo H. Ley Jr.

M.D.

ADDRESS (Street, city or town, state)

DATE SIGNED

PHYSICIAN'S
NAME (Type)

LEO H. LEY, JR. MD.

456 N. Centre St.

4/8/56

Cumberland, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

22b. DATE THEREOF

4/10/56

22c. NAME OF CEMETERY OR CREMATORIUM

Rose Hill Cemetery

22d. LOCATION (City, town, or county)

Cumberland, Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

H. Lee Silcox

Cumberland, Md.

ADDRESS

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

April 10, 1956 W.R. Frank, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 4
 15M 9/55

WISCONSIN STATE DIVISION OF HIGHWAY ENGINEERING

STATE OF WISCONSIN

RECEIVED
APR 11 1956
BUREAU V. S.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transfer permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03471

9

CERTIFICATE OF DEATH

3541

Reg. Dist. No.

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN give nearest town)	Allegany Frostburg	MARYLAND LENGTH OF STAY (in this place) 1 wk.	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Zihlman
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) THOMAS		4. DATE (Month) (Day) (Year) OF DEATH April 29, 1956	
5. SEX Male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH 6-28-1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired miner		10b. KIND OF BUSINESS OR INDUSTRY coal mines	
13. FATHER'S NAME Elizabeth Evans		11. BIRTHPLACE (State or foreign country) Maryland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) Yes		16. SOCIAL SECURITY NO. none	
17. INFORMANT & ADDRESS John Wm. Dickey		18. MEDICAL CERTIFICATION Myocardial Insufficiency Pulmonary Edema	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21c. WHERE DID INJURY OCCUR? (City or town) (County)		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Apr 18, 1956</u> , to <u>Apr 29, 1956</u> , that I last saw the deceased alive on <u>Apr 18, 1956</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Wm. J. Dickey</u>		ADDRESS (Street, city, town, state) Frostburg, Md.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 5-1-56	
24. REC'D BY REGISTRAR DATE 5-1-56		NAME OF CEMETERY OR CREMATORIAL F'lg. Memorial Park	
REGISTRAR'S SIGNATURE Mrs. Nancy A. Roe		LOCATION (City, town, or county) Frostburg, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.		ADDRESS	

ST. DOMINIC'S TRINITY COLLEGE STATE OF HAWAII

CERTIFICATE OF DEATH

1950-1951

DEATH CERTIFICATE NUMBER

NAME OF DECEASED

BUREAU V. A.

MAY 8 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, case execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3542 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03472
9

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg		c. LENGTH OF STAY IN 1b 50 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Miners Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg	
d. STREET ADDRESS 188 Ormond St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Harry Edward Dishong		4. DATE OF DEATH April 6 1956	Month Day Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 7-1890
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Mining Coal	
11. BIRTHPLACE (State or foreign country) Johnstown, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Dishong		14. MOTHER'S MAIDEN NAME Elizabeth Orner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-01-3670	
17. INFORMANT Miners Hospital records, Frostburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>002X</u> <u>Hyocardial failure</u> INTERVAL BETWEEN ONSET AND DEATH 1 day			
DUE TO { Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary tuberculosis</u> about 9 yrs.			
DUE TO (c) <u>Silicosis</u> about 8 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
19			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>	DATE SIGNED M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 7-1956		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-10-1956	22c. NAME OF CEMETERY OR CREMATORIUM St. Michael's Cemetery	22d. LOCATION (City, town, or county) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,		ADDRESS Frostburg, Md.	24a. REC'D BY REGISTRAR DATE 4-10-56
			24b. REGISTRAR'S SIGNATURE <i>James N. Roe</i>

MANITOBAN STATE GOVERNMENT OF HAMILTON - SASKATOON - 1956
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 16 1956

RECEIVED

3495

03473

CERTIFICATE OF DEATH

Reg. Dist. No. 4

DR. XXXXX RATHBONE

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 5 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRIENDSVILLE		d. STREET ADDRESS		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First WESLEY	Middle A	Last FIKE	4. DATE OF DEATH APRIL 29 1956	Month APRIL	Day 29	Year 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 14, 1889	9. AGE (In years last birthday) 66 yrs.	10. IF UNDER 1 YEAR Months 3	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME WILLIAM R. RIKE		14. MOTHER'S MAIDEN NAME ELLEN FRANTZ						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-14-0479		17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVE.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 204.1		DUE TO Myelogenous Leukemia		INTERVAL BETWEEN ONSET AND DEATH 3 mo				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from april 24, 1956 to april 30, 1956 , that I last saw the deceased alive on april 29, 1956 , and that death occurred at 8:15 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE R. Rhett Rathbone				ADDRESS (Street, city or town, state) 122 S. Centre St., Cumberland, Md.		DATE SIGNED		
PHYSICIAN'S NAME (Type) R. Rhett Rathbone, M. D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF May 2, 1956.		22c. NAME OF CEMETERY OR CREMATORIAL Saints Spring Cemetery		22d. LOCATION (City, town, or county) FRIENDSVILLE, Maryland		(State)
23. FUNERAL DIRECTOR'S SIGNATURE Rodolover Funeral Home, Markley's burg.		ADDRESS Elmwood Cemetery		24a. REG'D BY REGISTRAR DATE May 4, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frantz, M. D.		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon-poppers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE GOVERNMENT OF HAWAII—STATE OF HAWAII
DEPARTMENT OF REVENUE

BUREAU V.

MAY 3 1956

REGELY ED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3553 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03474

Reg. Dist. No.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. ATSM(E5)
5M 9/55

1. PLACE OF DEATH a. COUNTY Allegany				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklin		c. LENGTH OF STAY IN 1b 25 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Franklin		d. STREET ADDRESS		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Leslie		First	Middle	Last	4. DATE OF DEATH Month	Month	Day	Year
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	April 7-1908	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk or Timekeeper		10b. KIND OF BUSINESS OR INDUSTRY W. Va. Pulp & P.		11. BIRTHPLACE (State or foreign country) Honesdale, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Henry Fisher				14. MOTHER'S MAIDEN NAME Herriett Hilton				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-07-3437		17. INFORMANT (wife) Loretta L. Fisher, Franklin, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				Coronary occlusion			Address INTERVAL BETWEEN ONSET AND DEATH sudden	
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				Coronary sclerosis			?	
DUE TO (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>								
ACTUAL SIGNATURE H. V. Deming M.D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
DATE SIGNED April 16, 1956								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/18/56		22c. NAME OF CEMETERY OR CREMATORIAL Phelps Cemetery		22d. LOCATION (City, town, or county) Westernport Md		
23. FUNERAL DIRECTOR'S SIGNATURE C. B. - Westernport Md				ADDRESS		24a. REC'D BY REGISTRAR DATE 4-17-56	24b. REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly	

MISSOURI STATE DEPARTMENT OF HEALTH - DIVISION OF
MEDICAL EXAMINER'S OFFICE OF DEATH

BUREAU V. S
APR 19 1958
REGISTRY

Within corporate limits

may be retained by the hospital or attending physician and completely filled in by the funeral director.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3496 CERTIFICATE OF DEATH

03475

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 81 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24. North Waverly Terrace		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) First George Middle Joseph Last Forebeck		d. STREET ADDRESS 24 N. Waverly Terrace	
4. DATE OF DEATH Month April Day 27 Year 1956		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec 3 1874
9. AGE (In years lost birthday) 81 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter	11. KIND OF BUSINESS OR INDUSTRY Building Houses	12. BIRTHPLACE (State or foreign country) Cumberland, Md
13. FATHER'S NAME Joseph Forebeck	14. MOTHER'S MAIDEN NAME Katherine Armbruster		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 220-10-0648	17. INFORMANT Mrs. Martha Forbeck, Cumberland, Md.	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hæmorrhage</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) <i>Carcinoma of Stomach</i> DUE TO (c) <i>5 years</i> INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 10, 1955</i> , to <i>Apr. 27, 1956</i> , that I last saw the deceased alive on <i>Apr. 27, 1956</i> , and that death occurred at <i>10:30 P.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Clay E. Durrett</i>	ADDRESS (Street, city or town, state) <i>236 W. Main, Cumberland</i> DATE SIGNED <i>9/28/56</i>		
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 30 1956	22c. NAME OF CEMETERY OR CREMATORIAL Pleasant Grove Cem	22d. LOCATION (City, town, or county) (State) Cumberland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. F. Right</i>	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR <i>April 30, 1956</i>	24b. REGISTRAR'S SIGNATURE <i>W. F. Hantz, M.D.</i>

1938 CERTIFICATE OF DEATH

NAME

BUREAU V. S

MAY 1 1938

RECEIVED

Within corporate limits.

please excuse the certificate pending in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3497 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

034764

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Allegany MARYLAND		a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Allegany	
Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
c. LENGTH OF STAY IN 1b		c. STREET ADDRESS	
20 years		Cumberland 07	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
About 250 Ft. east of Williams St.		217 Union St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Gilbert		H	Friend
4. DATE OF DEATH		Month	Day
		April	20
		Year	1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
male		white	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 24-1890 65 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
Yard brakeman		B.O.R.Ry.	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Swanton, Md.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
John B. Friend		Harriett Comp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		Mr. Sweitzer, Bedford Rd. Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d)		INTERVAL BETWEEN ONSET AND DEATH sudden	
Exsanguination			
DUE TO (a) Conditions, if any, which gave rise to immediate cause		body severed at upper part of chest.	
DUE TO (b)			
DUE TO (c) Freight train ran over him.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
Freight train ran over him near William St. crossing.			
20c. TIME OF INJURY Month, Day, Year		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
4.20 p.m. 4-20 1956		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		B&O R.Ry.	
20f. (City or town)		(County)	
Cumberland		Allegany	
(State)		Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE <i>H.V. Denning M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Denning M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 23, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL George Cemetery		22d. LOCATION (City, town, or county) (State)	
		Swanton, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE Silcox Funeral Home, Cumberland, Maryland.		24a. REC'D BY REGISTRAR April 24, 1956	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>W.F. Frantz, M.D.</i>	

BUREAU V. S.

APR 24 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3498

CERTIFICATE OF DEATH

03477

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 214 Maryland Ave.,		d. STREET ADDRESS 214 Maryland Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) RAYMOND		First HENRY	Middle GOSS
4. DATE OF DEATH April	Month 17	Day 19	Year 56
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH March 5, 1900
9. AGE (In years lost birthday) 56	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman	11. BIRTHPLACE (State or foreign country) Cumberland, Maryland	12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Charles W. Goss	14. MOTHER'S MAIDEN NAME Margaret M. Main	15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 219-03-8607	17. INFORMANT Mrs. Helen Goss, 214 Maryland Ave. Cumb. Md.	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
INTERVAL BETWEEN ONSET AND DEATH Indirect			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma left lower alveolar process			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 3-23-56 to 4-17-56 , that I last saw the deceased alive on 4-11-56 , and that death occurred at 10:15 PM , from the causes and on the date stated above. ACTUAL SIGNATURE Dr. Zimmerman, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 20, 1956	22c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cemetery
22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		24a. REC'D BY REGISTRAR Philip, 1956	24b. REGISTRAR'S SIGNATURE W. Frank, M.D.
ADDRESS Cumberland, Md.			

DEPARTMENT OF HEALTH-ENVIRONMENT
CERTIFICATE OF DEATH

BUREAU V. S.

APR 23 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03478

3554

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Douglas Avenue		d. STREET ADDRESS Douglas Avenue	
3. NAME OF DECEASED (Type or print) Sarah Jane Gould		4. DATE OF DEATH April 1 1956	Month Day Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Jan 12, 1865	9. AGE (In years last birthday) yrs. 91
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Registered Nurse		10b. KIND OF BUSINESS OR INDUSTRY England	
11. BIRTHPLACE (State or foreign country) England		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elijah Gould		14. MOTHER'S MAIDEN NAME Ann Ball	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Olive Orr	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		"Sister" "Coronary Occlusion" "Arterosclerosis - Coronary & Generalized INTERVAL BETWEEN ONSET AND DEATH 8 hrs. 5-10 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. p.m. 19	Month, Day, Year p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1952 to 1956 , that I last saw the deceased alive on April 1956 , and that death occurred at 11 AM , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 51 Main Lonaconing	
ACTUAL SIGNATURE <i>George Eichhorn</i>	PHYSICIAN'S NAME (Type) George Eichhorn	DATE SIGNED 4-1-56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/4/56	22c. NAME OF CEMETERY OR CREMATORIAL Oak Hill	22d. LOCATION (City, town, or county) Lonaconing, Md.
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.	24a. REC'D BY REGISTRAR DATE 4-4-56
			24b. REGISTRAR'S SIGNATURE Jeanette M. Boal

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

81. ДІЯЛІТЬ СІДІТЬ ВІДІМКА СІДІТЬ ОПІДІМКА

BUREAU Y.

APR 13 1956

REGELY ED
1956. 12. 29.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3499

CERTIFICATE OF DEATH

03479

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LONACONING		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First (TWIN #2)	Middle BABY	Last BOY	4. DATE OF DEATH	Month APRIL	Day 10	Year 1956
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APRIL 16, 1956	9. AGE (In years last birthday) yrs. 12	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 12	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME SAMUEL D. HARTMAN			14. MOTHER'S MAIDEN NAME ALMA A. WARNICK				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Ruptured Spleen from Cardiac Neck							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Ruptured Spleen from Cardiac Neck					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 10:18 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Fuller B. Whitworth, M.D.							
DATE SIGNED							
ACTUAL SIGNATURE Fuller B. Whitworth, M.D.							
PHYSICIAN'S NAME (Type)		Fuller B. Whitworth, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 19, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) Lonaconing, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE George Euchuan Lanning		ADDRESS 432		24a. REC'D BY REGISTRAR DATE		24b. REGISTRAR'S SIGNATURE E.R. Frantz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILMINGTON STATEMENT TO HERALD—BALTIMORE 18

CERTIFICATE OF CABLE

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BUREAU V. S.

APR 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3500

CERTIFICATE OF DEATH

03480

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 34 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LaVale	
3. NAME OF DECEASED (Type or print) First Virgil Middle Lenwood Last Hartsock		d. STREET ADDRESS LaVale, National Hwy	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 8, 1890	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Contractor		10b. KIND OF BUSINESS OR INDUSTRY Standard Oil Co.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Cumberland U.S.A.	
13. FATHER'S NAME Howard Hartsock		14. MOTHER'S MAIDEN NAME Mary E. Weber	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 70		16. SOCIAL SECURITY NO. 232-26-3495	
17. INFORMANT Pt's chart		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO cardiac failure INTERVAL BETWEEN ONSET AND DEATH 1 yr.			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO coronary heart disease (c) DUE TO spontaneous pulmonary embolism 10 yrs 1 week			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) apertures perorrhary, cerebral embolism, cerebral vascular			
19. WAS AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from May 1953 to April 29, 1956 , that I last saw the deceased alive on April 29, 1956 , and that death occurred at 11 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. J. Hafer		M.D. ADDRESS (Street, city or town, state) 55 Greene St	
PHYSICIAN'S NAME (Type) EDZ. BRINGES		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 5/2/56	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Bur. Park	22d. LOCATION (City, town, or county) (State) Cumberland, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland		ADDRESS John J. Hafer, Cumberland, Maryland	
24a. REC'D BY REGISTRAR May 2, 1956		24b. REGISTRAR'S SIGNATURE W. H. Faatz, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S

MAY 4 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03481
Reg. Dist. No. 4

3501

1. PLACE OF DEATH o. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 72 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) First William Middle ARTHUR		d. STREET ADDRESS 8 BROWNING STREET	
4. DATE OF DEATH LAST HOLLAR		Month APRIL	Day Year 28 1956
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH OCTOBER 26, 1873	
9. AGE (In years lost birthday) 82 yrs.		10. IF UNDER 1 YEAR Months 82	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Co-Operator		10b. KIND OF BUSINESS OR INDUSTRY Bottling Company	
11. BIRTHPLACE (State or foreign country) PENNA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME GEORGE HOLLAR		14. MOTHER'S MAIDEN NAME NANCY MEASE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-05-8588	
17. INFORMANT Memorial Hospital		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Left Ventricular Failure		Immediate	
DUE TO 420.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Myocardial Fibrosis with Decompensation		73 days	
DUE TO (c) Coronary Arteriosclerosis		?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Uremia			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-16-1956 to 4-28-1956 that I last saw the deceased alive on April 27, 1956 , and that death occurred at 10:05 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street, Cumberland, Md.		DATE SIGNED 4-30-56	
ACTUAL SIGNATURE <i>Samuel Jacobson</i>		M.D.	
PHYSICIAN'S NAME (Type) Samuel M. Jacobson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 1, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Maryland.		24a. REC'D BY REGISTRAR DATE April 30, 1956	
		24b. REGISTRAR'S SIGNATURE W. Frank M.D.	

BY THE GOVERNOR OF THE STATE OF NEW YORK

LETTER TO THE

GENERAL

COMMISSION

OF THE STATE

OF NEW YORK

FOR THE

RECEIPT OF

THE

AMOUNT

OF

THE

FEDERAL BUREAU OF INVESTIGATION

MAY 1, 1937

FEDERAL BUREAU OF INVESTIGATION

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, use entire certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

FORWARDED TO THE CHIEF MEDICAL EXAMINER'S OFFICE ALONG WITH FORM PM3. PAGE 5 MAY BE RETAINED FOR YOUR FILES.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3502 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03482

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	b. COUNTY Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	c. LENGTH OF STAY IN 1b 65 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	d. STREET ADDRESS 470 Central Ave.				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Brooks Hotel	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) Harry	First F.	Middle Hughes	4. DATE OF DEATH April 10 1956				
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Jan. 21-1891				
8. WIDOWED <input type="checkbox"/>	9. DIVORCED <input type="checkbox"/>	10. AGE (In years last birthday) 65 yrs.	11. IF UNDER 1 YEAR Months 0 Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Insulator		10b. KIND OF BUSINESS OR INDUSTRY Celanese Corp.	11. BIRTHPLACE (State or foreign country) Cumberland, Md.				
13. FATHER'S NAME Joseph Hughes		14. MOTHER'S MAIDEN NAME Minnie Damm			15. IF UNDER 24 HRS. Address		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-10-6518	17. INFORMANT (son) Richard Hughes, Cumberland, Md.	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure INTERVAL BETWEEN ONSET AND DEATH DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Chronic myocarditis several years.			
		(b) Chronic myocarditis	(c) Cardiac hypertrophy	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Maryland (State) Maryland		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE H. V. Deming M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED April 10-1956		
EXAMINER'S NAME (Type) H. V. Deming M.D.	22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF April 13, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	22d. LOCATION (City, town, or county) Cumberland, Maryland (State) Maryland
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Maryland.	ADDRESS Knight				24a. REC'D BY REGISTRAR April 12, 1956	24b. REGISTRAR'S SIGNATURE W. R. Frank, M.D.	
VS. A15ME(5) 5M 9/55							

STATE OF HAWAII - DEPARTMENT OF
GENERAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

APR 13 1956

RECEIVED

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03483

3543

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Frostburg	MARYLAND LENGTH OF STAY (in this place) 5 wks.	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Maryland Frostburg
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Miners Hospital		STREET ADDRESS (If rural give location) 68 W. Main St.
3. NAME OF DECEASED (Type or Print)	(First) WILLIAM	(Middle) HOCKING	(Last) JEFFRIES
4. DATE OF DEATH	April 1, 1956		(Month) (Day) (Year)
5. SEX male	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) single	8. DATE OF BIRTH 10-30-1871
9. AGE last birthday 84 yrs.	10. KIND OF BUSINESS OR INDUSTRY Lumber yard	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Samuel Jeffries	14. MOTHER'S MAIDEN NAME Mary Susan Hocking		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO. 220-16-6693		17. INFORMANT & ADDRESS Charles Jeffries, Frostburg, Md.
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 450.0 IMMEDIATE CAUSE (A) <i>Arterio Sclerosis</i>		18. MEDICAL CERTIFICATION ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) _____ GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____ INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. et work	21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <i>Apr. 9, 1956</i> , to <i>Apr. 1, 1956</i> , that I last saw the deceased alive on <i>Apr. 1, 1956</i> , and that death occurred at <i>1:30 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>John McNamee</i> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE HEREOF 4-3-1956	ADDRESS (Street, city, town, state) <i>Frostburg, Md.</i> DATE SIGNED <i>4-3-56</i>
24. REC'D BY REGISTRAR DATE 4-3-56		REGISTRAR'S SIGNATURE <i>Mrs. Nancy N. Rose</i>	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS J. R. Durst, Frostburg, Md.

87 (REQUEST TO HEAR-BALTIMORE STATE CHARTER)

CERTIFICATE OF DEATH

NAME OF DECEASED

BUREAU U. S.

APR 9 19

REGELVED

3503

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 40 hours	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Edmund		First J.	Middle Joseph
4. DATE OF DEATH April 9 1956		5. SEX Male	6. COLOR OR RACE White
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 6-7-94	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired store prop.		10b. KIND OF BUSINESS OR INDUSTRY Paint Business	
11. BIRTHPLACE (State or foreign country) Cumberland,		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Daniel Kean		14. MOTHER'S MAIDEN NAME Mary Landwehr Kean	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO. 17. INFORMANT Mrs. Nancy Kean 109 N. Chase St., Cumberland,	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Thromboses Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO 3rd attack (c)		INTERVAL BETWEEN ONSET AND DEATH 10 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3-31 , 19 56 , to 4-9 , 19 56 that I last saw the deceased alive on 4-9 , 19 56 , and that death occurred at 2:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE R. B. Mathews M.D.		ADDRESS (Street, city or town, state) 49 Green St Cumberland Md.	
PHYSICIAN'S NAME (Type) R. B. Mathews M.D.		DATE SIGNED 4/12/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/12/56	
22c. NAME OF CEMETERY OR CREMATORIAL S. S. Peter & Pauls		22d. LOCATION (City, town, or county) (State) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Maryland	
24a. REC'D BY REGISTRAR April 12, 1956		24b. REGISTRAR'S SIGNATURE W. L. Frank, M. D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. S.

APR 13 1956

RECEIVED

3574

CERTIFICATE OF DEATH

03485

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE	
Allegany MARYLAND		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
Cumberland		35 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS	
572 Cromwell Terrace		572 Cromwell Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
Elsie		Lavene	Kilroy
4. DATE OF DEATH		Month	Day
April		5	1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years lost birthday)	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Dots Hours Min.
Dec. 6, 1900		55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)
Housekeeper		At	Frostburg, Md.
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Frank Clark		Julia Miller	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
no		none	
17. INFORMANT		Address	
E. C. Kilroy Sr.		Cumberland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
155X			
DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost.		(b) <i>Carcinoma gall bladder</i>	
DUE TO		(c) <i>metastasis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3130, 1956, to 415, 1956, that I last saw the deceased alive on 415, 1956, and that death occurred at M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	
ACTUAL SIGNATURE <i>George M. Simons</i> M.D.		DATE SIGNED 4/18/56	
PHYSICIAN'S NAME (Type) George M. Simons, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/56	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Cem.		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR April 8, 1956		24b. REGISTRAR'S SIGNATURE <i>Mr. Frank, M.D.</i>	

FEDERAL BUREAU OF INVESTIGATION

APR 10 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03486

DR. HODGES

3505

CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HRS. 29 MIN.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND, rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) BABY		First BOY	Middle 	Last KNIPPENBERG	4. DATE OF DEATH APRIL 7, 1956	Month APRIL	Day 7	Year 56			
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH APRIL 7, 1956	9. AGE (In years lost birthday) yrs. 0 Months 0 Days 0 Hours 29	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME JEAN L. KNIPPENBERG			14. MOTHER'S MAIDEN NAME MARY R. COLLIER								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]											INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5											
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)											
DUE TO Prematurity - 7 1/2 Mon.											
DUE TO Central Placenta Previa											
DUE TO - repeated Hemorrhage - Cœsarian.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour a. m. p. m. 19		Month 19	Doy 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland, Md.	(County) Md.	(State) Md.		
21. I certify that I attended the deceased from April 7, 1956 to April 17, 1956 that I last saw the deceased alive on April 7, 1956 , and that death occurred at 10:30 A.M. from the causes and on the date stated above.											
ACTUAL SIGNATURE W. Royce Hodges											ADDRESS (Street, city or town, state) Cumberland, Md.
PHYSICIAN'S NAME (Type) W. ROYCE HODGES, M.D.											DATE SIGNED 4/18/56
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-9-56		22c. NAME OF CEMETERY OR CREMATORIUM Zion Memorial Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State) Md.			
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpetti		ADDRESS James F. Scarpetti, Cumberland, Md.		24a. REC'D BY REGISTRAR April 9, 1956		24b. REGISTRAR'S SIGNATURE W. Franz, M.D.					

• 11 •

BUREAU V. S.

APR 10 1956

REGELY EU

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

03487

Reg. Dist. No. 6

3544

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
CITY OR TOWN		COUNTY Allegany		MARYLAND		STATE Maryland CITY OR TOWN Westernport	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)				COUNTY Allegany	
TOWN Westernport							
HOSPITAL OR INSTITUTION OR STREET ADDRESS 135 Front Street				STREET ADDRESS 135 Front Street			
3. NAME OF DECEASED (First) Clarissa (Type or Print)				(Middle) May (Last) Kohne			
4. DATE OF DEATH April 9, 1956				(Month) (Day) (Year)			
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH May 20, 1894	9. AGE last birthday 61	IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) Moorefield, W. Va.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Lee Whetzell				14. MOTHER'S MAIDEN NAME Sarah Bean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.			
17. INFORMANT & ADDRESS							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443x IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive cardiovascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, DUE TO (C)							
GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
INTERVAL BETWEEN ONSET AND DEATH 12 hours							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)				21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?							
22. I hereby certify that I attended the deceased from <u>Feb. 21, 1956</u> , to <u>April 9, 1956</u> , that I last saw the deceased alive on <u>April 9, 1956</u> , and that death occurred at <u>5pm</u> , M, from the causes and on the date stated above.							
SIGNATURE <u>James D. Johnson</u> M.D.							
ADDRESS (Street, city, town, state) <u>Predmont W. Va</u> DATE SIGNED <u>4-11-56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				DATE THEREOF 4-12-56			
NAME OF CEMETERY OR CREMATORIAL Philos				LOCATION (City, town, or county) WESTERNPORT, Md.			
24. REC'D BY REGISTRAR DATE 4-12-56				REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly			
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				Rogen Funeral Home, Keyes, W. Va.			

BUREAU V. S.

APR 13 1956

REGELY ED

1 Within corporate limits

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03488

3506 CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

COUNTY

Allegany

MARYLAND

CITY (If outside corporate limits, write RURAL
OR
and give nearest town)
TOWN

Cumberland

LENGTH OF STAY
(In this place)

10/13/53

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

91 Allegany County Infirmary

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE

Maryland

COUNTY

Allegany

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWN

Frostburg

STREET
ADDRESS

163 McCulloh Street

(If rural give location)

**3. NAME OF
DECEASED
(Type or Print)**

(First)
John

(Middle)
A.

(Last)
Kopper, Sr.

**4. DATE
OF
DEATH** April 6, 1956

5. SEX

Male

6. COLOR OR
RACE

White

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Widower

8. DATE OF BIRTH

5/16/1879

9. AGE last birthday
yrs.

76

10. IF UNDER 1 YEAR
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if
retired)

Retired - Carpenter - Mining

10b. KIND OF BUSINESS
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Czecho Slovakia

12. CITIZEN OF WHAT
COUNTRY?

U. S. A.

13. FATHER'S NAME

George Kopper

14. MOTHER'S MAIDEN NAME

Susan Sova

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

212-18-1649 A

17. INFORMANT & ADDRESS

Allegany County Infirmary Records

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.1 IMMEDIATE CAUSE (A)

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE
STATING UNDERLYING CAUSE LAST. DUE TO

(C)

18. MEDICAL CERTIFICATION

Pulmonary Hypostasis

INTERVAL BETWEEN
ONSET AND DEATH

48 hrs

Chronic Myocarditis

?

General Arteriosclerosis

>

Diabetes Mellitus

?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?
YES NO

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. PLACE (Home, farm, factory,
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED
M. While Not white
el work el work

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from

alive on April 6th, 1956, to April 6th, 1956, that death occurred at 11 a.m. from the causes and on the date stated above.
ADDRESS (Street, city, town, state) 449 Greene St.
DATE SIGNED 4-6-56

SIGNATURE
J. Michael S. McLean

M.D.

DATE 4-6-56

BURIAL, CREMATION,
REMOVAL (SPECIFY)

Burial

DATE THEREOF

4-9-1956

NAME OF CEMETERY OR CREMATORI

St. Michael's Cemetery

LOCATION (City, town, or county)

Frostburg, Md.

(State)

REC'D BY REGISTRAR

DATE April 7, 1956

REGISTRAR'S SIGNATURE

Winter R. Hantz, M.D.

25. FUNERAL DIRECTOR'S SIGNATURE

J. R. Durst, Frostburg, Md.

ADDRESS

RECEIVED
APR 10 1956
BUREAU V. S.

3507

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE WEST VIRGINIA		b. COUNTY HAMPSHIRE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROMNEY		d. STREET ADDRESS 85x-3	
d. NAME OF HOSPITAL (If outside corporate limits, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First SAMUEL	Middle SCOTT	Last LANDIS	4. DATE OF DEATH	Month APRIL	Day 2	Year 1956
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> May 5, 1874	9. AGE (In years less birthday) 81	IF UNDER 1 YEAR Months 81	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) W.VA., GRANT COUNTY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ABRAHAM F. LANDIS		14. MOTHER'S MAIDEN NAME ELIZA BORROR					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X		DUE TO Cerebral vascular accident		INTERVAL BETWEEN ONSET AND DEATH 3 days			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Generalized arteriosclerosis					
(c) DUE TO Diabetes mellitus							
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Doy 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from 3/31/1956 to 4/1/1956 , that I last saw the deceased alive on 4/1/1956 , and that death occurred at 12:15 PM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) ADDRESS		DATE SIGNED DATE SIGNED	
ACTUAL SIGNATURE George M. Simons		M.D.					
PHYSICIAN'S NAME (Type) GEORGE M. SIMONS, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF April 5, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Indian Mound Cemetery		22d. LOCATION (City, town, or county) Romney, West Virginia		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Keith S. Steffens		ADDRESS Romney, W. Va.		24a. REC'D BY REGISTRAR April 4, 1956		24b. REGISTRAR'S SIGNATURE W. Gandy, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03491

DR. HIMMELWRIGHT 3508 CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 may be retained by the hospital or attending physician and completely filled in by the funeral director.
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/55

1. PLACE OF DEATH o. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		d. STREET ADDRESS 434 RACE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ANNA	First M.	Middle LEPLEY	Last LEPLEY	4. DATE OF DEATH FEB. 26 1883	Month APRIL	Day 21	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH FEB. 26 1883	9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? Oldtown U. S. A.	
13. FATHER'S NAME David STUMP		14. MOTHER'S MAIDEN NAME Chloe McCulley					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL - WARWICK & MEMORIAL AVES.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Uremia</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <i>Arthrosclerotic Cardio Vascular Disease</i> DUE TO (c) <i>Diabetes Mellitus</i>							
INTERVAL BETWEEN ONSET AND DEATH 5 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 260x Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 21, 1955 to April 24, 1956 , that I last saw the deceased alive on April 21, 1956 , and that death occurred at 4:36 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Overton Himmelwright, M.D.</i>		ADDRESS (Street, city or town, state) 133 Virginia Ave., Cumberland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-24-56		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Burial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.		24a. REC'D. BY REGISTRAR April 24, 1956		24b. REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	

Within corporate limits.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3509 CERTIFICATE OF DEATH

03492

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: Enter this certificate has been signed by the attending physician and completely filled in by the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION D.O.A. Memorial Hospital		d. STREET ADDRESS 443 N. Centre St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Minnie	First	Middle	Last	4. DATE OF DEATH April	Month	Day	Year 26 1956	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Unknown	9. AGE (In years lost birthday) 72	IF UNDER 1 YEAR Months 72	IF UNDER 24 HRS. Days 0	Hours 0	Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Russia		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Joseph Lansman				14. MOTHER'S MAIDEN NAME Unknown				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		17. INFORMANT Harry Stein		Address Cumberland, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident (Hemorrhage) INTERVAL BETWEEN ONSET AND DEATH Immediate DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Cerebral Arteriosclerosis ? DUE TO (c)								
260X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from October 3, 1955 , to April 26, 1956 , that I last saw the deceased alive on April 21, 1956 , and that death occurred at 6:00PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street DATE SIGNED April 27, 1956 ACTUAL SIGNATURE Samuel M. Jacobson, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/56		22c. NAME OF CEMETERY OR CREMATORIAL East View Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc. ADDRESS Cumberland, Md. 24a. REC'D BY REGISTRAR April 27, 1956 24b. REGISTRAR'S SIGNATURE W. Frank M.D.								

STATE OF ALABAMA - DEATH - DEATH PENALTY

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03493

3555

CERTIFICATE OF DEATH

Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St Marys Terrace		d. STREET ADDRESS St Marys Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Michael	Middle A.	Last Marley
4. DATE OF DEATH	Month April	Day 3	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 9, 1878
9. AGE (In years from last birthday) 77	10. IF UNDER 1 YEAR Months 77	11. IF UNDER 24 HRS. Days 00	12. IF UNDER 24 HRS. Hours 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner	10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	11. BIRTHPLACE (State or foreign country) Westernport, Maryland	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Thomas J. Marley		14. MOTHER'S MAIDEN NAME Mary Ann McPartland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 179-03-4995	
17. INFORMANT William Marley		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterosclerotic Heart Disease DUE TO (c) 4-54.	
19. MEDICAL CERTIFICATION		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Bronchopneumonia - Resolving	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DATE OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 1952 to 3 April 1956 , that I last saw the deceased alive on 3 April 1956 , and that death occurred at 720 M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Lonaconing, Md.			
ACTUAL SIGNATURE George Richardson			
PHYSICIAN'S NAME (Type) George Richardson			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/6/1956	
22c. NAME OF CEMETERY OR CREMATORIAL St Marys		22d. LOCATION (City, town, or county) (State) Lonaconing, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR DATE 4-6-56	
ADDRESS Lonaconing, Md.		24b. REGISTRAR'S SIGNATURE Jeanette M. Good	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

D

BUREAU V. S.

APR 12 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 03494

3510 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		b. COUNTY Allegany	
c. LENGTH OF STAY IN 1b 21 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 60 Memorial Hospital		d. STREET ADDRESS 324 Estella St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Madeline		First B.	Middle Martin
4. DATE OF DEATH April 17 1956		Month April	Day 17
5. SEX Female		6. COLOR OR RACE colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> June 3-1924
9. AGE (In years last birthday) 31 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Springfield, W.Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Carter		14. MOTHER'S MAIDEN NAME Pearl Fairfax	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT Memorial Hospital records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 1 to 4th. degree burns of body, except, feet, back & head		19. INTERVAL BETWEEN ONSET AND DEATH gradual 21 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Oil stove exploded and her clothes caught fire.	
20c. TIME OF INJURY Month, Day, Year Hour 11.30 a.m. 3-27 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mother's Home		20f. (City or town) Springfield	
(County) W.Va.		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
ACTUAL SIGNATURE H.V. Deming M.D.		DATE SIGNED April 18-1956	
EXAMINER'S NAME (Type) H.V. Deming M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 20, 1956	
22c. NAME OF CEMETERY OR CEMETORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) Cumberland, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Cumberland, Maryland.		24a. REC'D BY REGISTRAR April 19, 1956	
ADDRESS Hafer		24b. REGISTRAR'S SIGNATURE J.W. Frantz, M.D.	

BUREAU V. S.
RECEIVED
APR 20 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

03495

Reg. Dist. No.

3545

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport		c. LENGTH OF STAY IN 1b 66 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 178 Main St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport 43	
d. STREET ADDRESS 178 Main		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frank		First Seymour	Middle Mayhew
4. DATE OF DEATH April	Month	Day 1	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH July 21, 1889
	WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. AGE (In years lost birthday) 66 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Westernport		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Mayhew		14. MOTHER'S MAIDEN NAME Amanda Sperling	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-03-7796A 17. INFORMANT Mrs. Frank Mayhew, Westernport, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 592 X		Address INTERVAL BETWEEN ONSET AND DEATH 1 Day	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		2 Months	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Feb. 25</u> , 1956, to <u>Apr. 1</u> , 1956, that I last saw the deceased alive on <u>Mar. 31</u> , 1956, and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. Piedmont, W.Va. DATE SIGNED 4-2-56			
ACTUAL SIGNATURE <i>Paula R. Wilson</i>	PHYSICIAN'S NAME (Type) PAUL R. WILSON M.D. Piedmont, W.Va.		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/4/56	22c. NAME OF CEMETERY OR CREMATORIUM Bloomington	22d. LOCATION (City, town, or county) Bloomington
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ellsworth S. Ball - Westernport</i>		24a. REC'D BY REGISTRAR DATE 4-2-56	
		24b. REGISTRAR'S SIGNATURE <i>Mrs. Jean C. Kelly</i>	

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APR 4 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3511

CERTIFICATE OF DEATH

03496
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 2 by 40 min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		d. STREET ADDRESS 20 South Street		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				d. STREET ADDRESS 20 South Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Mary		First	Middle	Last	4. DATE OF DEATH Mc Dermott	Month	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 9/3/85	9. AGE (In years last birthday) 70	IF UNDER 1 YEAR Months 70	IF UNDER 24 HRS. Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland, Cumberland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Nelson Long		14. MOTHER'S MAIDEN NAME Elizabeth Mc Coll		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Chart James L. McDermott				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X		DUE TO Cerebral Apsoplexy		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs.				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO		(c)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 105 S 8th	(County)	(State)		
21. I certify that I attended the deceased from 4-9- , 19 56 , to 4-24-56 , 19 56 , that I last saw the deceased alive on 4-24-56 , 19 56 , and that death occurred at 11:30 A.M. from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Cumberland, Md.		
ACTUAL SIGNATURE Dr. Zimmerman		M.D.				DATE SIGNED 4-25-56		
PHYSICIAN'S NAME (Type) Dr. Zimmerman								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-27-56	22c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cem	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)				
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		ADDRESS Cumberland, Md.	24a. REC'D. BY REGISTRAR April 26, 1956	24b. REGISTRAR'S SIGNATURE W.L. Frank, M.D.				

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3512

CERTIFICATE OF DEATH

03497

Reg. Dist. No. 4

Within corporate limits
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director.
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 hrs. 50 min.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SACRED HEART HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 705 GEPHART DRIVE	
3. NAME OF DECEASED (Type or print) JUDY BARBARA McFARLANE		4. DATE OF DEATH 4-21-1956	Month 4 Day 21 Year 56
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH JUNE 13, 1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME DAVID McFARLANE		14. MOTHER'S MAIDEN NAME HELEN KERSHEN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT David McFarlane		Address 705 Gephart Drive Cumb. Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.4 myo-endocarditis		INTERVAL BETWEEN ONSET AND DEATH 1 week	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) sore throat		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-22-1956 to 4-24-1956 , that I last saw the deceased alive on 4-24-56 , and that death occurred at 11 AM M, from the causes and on the date stated above. ACTUAL SIGNATURE L. Brings		ADDRESS (Street, city or town, state) 57 Greene St, Cumberland, Md DATE SIGNED 4-24-56	
PHYSICIAN'S NAME (Type) L. Brings, M.D.		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/27/56	
22d. LOCATION (City, town, or county) Cumberland, Maryland		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS CUMBERLAND, MD.	
24a. REC'D BY REGISTRAR April 28, 1956		24b. REGISTRAR'S SIGNATURE Winter R. Frantz, M.D.	

03498

3513 CERTIFICATE OF DEATH

Reg. Dist. No. 9

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After the certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of the death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10W

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Cumberland		MARYLAND LENGTH OF STAY 2 ^{1/2} yrs. 8 mo. 7 da	
HOSPITAL OR INSTITUTION OR STREET ADDRESS IX Sylvan Retreat		STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Cumberland	
3. NAME OF DECEASED (Type or Print) Mae Lee		4. DATE (Month) (Day) (Year) McKETRICK April 7 1956	
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH Feb. 19, 1871
9. AGE last birthday 85 yrs.	10. KIND OF BUSINESS OR INDUSTRY Housewife - Own Home		11. BIRTHPLACE (State or foreign country) Loudon, Virginia
12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME James Holt		14. MOTHER'S MAIDEN NAME Adeline Blanchard	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT & ADDRESS Addie M. Lewis, 227 offutt St., Cumb. Md.			
18. MEDICAL CERTIFICATION <i>Chronic Myocarditis</i> <i>General arteriosclerosis</i> <i>Secondary anemia</i> <i>Senile Psychosis</i>			
INTERVAL BETWEEN ONSET AND DEATH ?			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.1 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		?	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		?	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>July 25, 1953, to Apr. 7th, 1956</i> , that I last saw the deceased alive on <i>Apr. 7th, 1956</i> , and that death occurred at <i>5:50 P.M.</i> from the causes and on the date stated above. SIGNATURE <i>Spencer E. T. Dean</i> M.D. ADDRESS <i>49 Greene St.</i> DATE SIGNED <i>4-8-56</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF April 10, 1956	
24. REC'D BY REGISTRAR DATE <i>April 9, 1956</i>		NAME OF CEMETERY OR CREMATORIAL St. John's Cemetery	
REGISTRAR'S SIGNATURE <i>Winter R. Frank, M.D.</i>		LOCATION (City, town, or county) Ellicott City, Maryland.	
25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS James F. Scarpelli, Cumberland, Maryland.			

WISCONSIN STATE DEPARTMENT OF HEALTH - MEDICAL

1913 CERTIFICATE OF DEATH

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SEARCHED NO INDEXES MADE

BUREAU Y.

APR 10 1956

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CERTIFICATE OF DEATH

03499

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 4 DAYS		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. VA.		b. COUNTY HARDY			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MOOREFIELD		d. STREET ADDRESS 853		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First NELLIE		Middle F.		Last MC NEILL		4. DATE OF DEATH APRIL 18 1956	Month	Day	Year		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 1, 1908	9. AGE (In years last birthday) 47 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) W. VA.		12. CITIZEN OF WHAT COUNTRY? USA					
13. FATHER'S NAME HYDER SAVILLE		14. MOTHER'S MAIDEN NAME EMILY MESSICK		Address							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X				INTERVAL BETWEEN ONSET AND DEATH 4 days	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 		DUE TO (b)		DUE TO (c)		Cerebral Hemorrhage					
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Rheumatic Heart Disease, mitral, inactive										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>									
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) M.D.		(County)	(State)		
21. I certify that I attended the deceased from 18 am , 1956 to 18 pm , 1956 , that I last saw the deceased alive on 18 apr 56 , 19 , and that death occurred at 8:45 AM , from the causes and on the date stated above.										ADDRESS (Street, city or town, state) Moorefield, West Virginia	DATE SIGNED W. Alfred Van Ormer, M.D.
ACTUAL SIGNATURE W. Alfred Van Ormer		PHYSICIAN'S NAME (Type) W. Alfred Van Ormer, M.D.									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Olivet Cemetery		22d. LOCATION (City, town, or county) Moorefield, West Virginia				(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Reid Steffen		ADDRESS Romney W. Va.		24a. REC'D BY REGISTRAR April 19, 1956		24b. REGISTRAR'S SIGNATURE W.R. Hanty, M.D.					

01 380-01148-51116-0 00000000000000000000000000000000

BUREAU V. S.

APR 20 1956

APR 20 1975
REF ID: VED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8, Film G195 1-13-56 et

03500

CERTIFICATE OF DEATH

Reg. Dist. No.

3515

1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

OR INSTITUTION

Sacred Heart Hospital

d. NAME OF HOSPITAL (If not in hospital, give street address)

OR INSTITUTION

Sacred Heart Hospital

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STATE OF CALIFORNIA
DEPARTMENT OF MOTOR VEHICLES

RECEIVED APR 10 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3516

CERTIFICATE OF DEATH

03501

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		c. LENGTH OF STAY IN 1b 3 Hr.-45 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barton		d. STREET ADDRESS					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital											
3. NAME OF DECEASED (Type or print) Mary		First Mary	Middle Ann	Last Miller	4. DATE OF DEATH 4/15/1956	Month 4	Day 15	Year 1956			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/7/1884	9. AGE (In years lost birthday) 71 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Joseph Bradley				14. MOTHER'S MAIDEN NAME Martha McGimsey		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Pt. 's Chart		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) DUE TO myocardial infarction Coronary Occlusion Arterosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 18 hrs.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21. I certify that I attended the deceased from June 19, 1956 to 15 April, 1956 that I last saw the deceased alive on 15 April, 1956 , and that death occurred at 7:40 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE George J. Richards PHYSICIAN'S NAME (Type) George J. Richards, M.D.		22. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Lonaconing, Md.	20f. (City or town) Lonaconing, Md.	(County) W. Va.	(State) W. Va.
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 18, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Laurel Hill Cemetery		22d. LOCATION (City, town, or county) Moscow, Maryland.		(State) W. Va.			
23. FUNERAL DIRECTOR'S SIGNATURE Boals		ADDRESS Westernport, Md.		24a. REC'D. BY REGISTRAR Jul 17, 1956		24b. REGISTRAR'S SIGNATURE W. F. Franz, M.D.					

WISCONSIN STATE BANKS OF MOUNTAIN - CALUMETTE

CERTIFICATE OF DEATH

BUREAU V. S.

APR 18 1955

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3517

CERTIFICATE OF DEATH

Reg. Dist. No.

135124

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W. Va.		b. COUNTY Mineral		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 Hr-55 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Keyser, W. Va.		d. STREET ADDRESS 196 Armstrong St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Baby		First Baby	Middle Girl	Last Mills	4. DATE OF DEATH April, 15, 1956	Month April	Day 15	Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/15/56		9. AGE (In years lost birthday) yrs. 1	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 55
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Lloyd Mills				14. MOTHER'S MAIDEN NAME Mary Katherine Norris				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mother's Chart		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 761.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c) Prematurity								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Premature Rupture Mem.								
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED								
ACTUAL SIGNATURE F. B. Whitworth, M.D.								
PHYSICIAN'S NAME (Type)		123 Bedford Street, Cumberland, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 16, 1956		22c. NAME OF CEMETERY OR CREMATORIUM Queen's Point Cemetery		22d. LOCATION (City, town, or county) Keyser, West Virginia		
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		
Roger Funeral Home, Keyser, W. Va.				DATE April 19, 1956		Ed. Frantz, M.D.		

RECEIVED - BUREAU OF INVESTIGATION - FEDERAL BUREAU OF INVESTIGATION - APRIL 20, 1956

RECEIVED - BUREAU OF INVESTIGATION - APRIL 20, 1956

BUREAU V. 2

APR 20 1956

RECEIVED

3518

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. LENGTH OF STAY IN 1b 40 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 00 144. Frederick St		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) First Annetta		d. STREET ADDRESS 144. Frederick St	
4. DATE OF DEATH April 19		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH DIVORCED <input type="checkbox"/> January 12 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own House	
11. BIRTHPLACE (State or foreign country) Burlington, West Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Taylor Oats		14. MOTHER'S MAIDEN NAME Mattie Oats	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Charles P. Montgomery, Cumberland, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Uterus with Metastasis</i>		INTERVAL BETWEEN ONSET AND DEATH 2 years	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>July 1955</i> to <i>April 1956</i> , that I last saw the deceased alive on <i>April 8, 1956</i> , and that death occurred at <i>4 PM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. T. Johnson, Jr.</i>		ADDRESS (Street, city or town, state) <i>Cumberland, Md.</i> DATE SIGNED <i>4-1956</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 21 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William H. Knight</i>		24a. REC'D BY REGISTRAR C. Frank, M.D.	
ADDRESS Cumberland, Md.		24b. REGISTRAR'S SIGNATURE <i>W. Frank, M.D.</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the physician or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

278

BUREAU V. S.
APR 23 1956
RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

3556

CERTIFICATE OF DEATH

03504
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep		c. LENGTH OF STAY IN 1b 45 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 50		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Nikep	
3. NAME OF DECEASED (Type or print) Cecil		First E.	Middle Munson
4. DATE OF DEATH April	Month 26	Day 1956	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 4, 1910
9. AGE (In years lost birthday) 45 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith	10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.	11. BIRTHPLACE (State or foreign country) Nikep, Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Joshua Munson		14. MOTHER'S MAIDEN NAME Elizabeth Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 232-01-1313	
17. INFORMANT Daisy Munson		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 415X Due to Cardiac Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Due to Chronic Arteritis and Myocardial Deficiency (c) Specified as Rheumatic 34 Years	
		INTERVAL BETWEEN ONSET AND DEATH 2 Months	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. None 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 25, 1956 , to April 26, 1956 , that I last saw the deceased alive on April 24, 1956 , and that death occurred at 5:00 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Paul B. Wilson M.D. Piedmont, W. Va. Apr. 26, 1956			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Laurel Hill		22d. LOCATION (City, town, or county) (State) Moscow, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		24a. REC'D BY REGISTRAR DATE 4-28-56	
ADDRESS Lonaconing, Md.		24b. REGISTRAR'S SIGNATURE Jeanette M. Boal	

STATE OF MARYLAND - SALVATION ARMY		CERTIFICATE OF DEATH	
NAME	ADDRESS	NAME	ADDRESS
AGE	SEX	AGE	SEX
DEATH DATE	TIME	DEATH DATE	TIME
CAUSE OF DEATH	DEATH CERTIFICATE NO.	CAUSE OF DEATH	DEATH CERTIFICATE NO.
REMARKS		REMARKS	
BUREAU Y. S.		BUREAU Y. S.	
MAY 1 1936		MAY 1 1936	
KELLOGG		KELLOGG	

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03505

CERTIFICATE OF DEATH

Reg. Dist. No. 4

Within corporate limits.

3519

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY		Allegany		MARYLAND		STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL or end give nearest town)				LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		Cumberland		3 Yrs		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
758 Fayette St.				758 Fayette St.			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Grace Elizabeth Murray				April 13 1956			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Female	White	Married	10/7/1913	42 yrs.	Months	Days	Hours Min.
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)			
Office Work		Newspaper		Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Coleman				Anna Decker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		217 10 1061		Walter Murray Cumberland, Md.			
No							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) Coronary Occlusion							
ANTECEDENT CAUSE(S) DUE TO (B) Coronary Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Acute Anterior Myocardial Infarction							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While Not while M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from....1-1-56....., 19....., to.....4-13-56....., 19....., that I last saw the deceased alive on.....4-13-56....., 19....., and that death occurred at.....10.....p.m., from the causes and on the date stated above.							
SIGNATURE 							
ADDRESS (Street, city, town, state) M.D. 50 Pershing St., Cumberland, Md. DATE SIGNED 4-14-56							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF 4/16/56		NAME OF CEMETERY OR CREMATORIAL St. Peter & Paul		LOCATION (City, town, or county) Cumberland, Maryland (State)	
Burial							
24. REC'D BY REGISTRAR DATE		REGISTRAR'S SIGNATURE W. R. Dranty, M.D.		25. FUNERAL DIRECTOR'S SIGNATURE Louis Stein, Inc.		ADDRESS Cumberland, Md.	
Apr. 16, 1956							

DEPARTMENT OF STATE - BUREAU OF INTELLIGENCE - TELETYPE

RELEASING OF DATA

BUREAU V. S.

APR 18 1958

REG-144-4

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03506

DR. LEY

3520

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 16 W. FIRST ST.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL				d. STREET ADDRESS CUMBERLAND		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)	First PATRICK	Middle O.	Last MYERS	4. DATE OF DEATH APRIL 7 1956	Month APRIL	Day 7	Year 56
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JULY 14, 1891	9. AGE (In years lost birthday) 64 yrs.	IF UNDER 1 YEAR Months 6	IF UNDER 24 HRS. Days 0	Hours 0

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Labor	10b. KIND OF BUSINESS OR INDUSTRY Orchard Industry	11. BIRTHPLACE (State or foreign country) W.V.A. Greenspring	12. CITIZEN OF WHAT COUNTRY? U. S. A.
--	--	--	---

13. FATHER'S NAME WILSON WATSON MYERS	14. MOTHER'S MAIDEN NAME ELSIE STOTTLER STOTTLER
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	16. SOCIAL SECURITY NO. none	17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVES.	Address
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18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		<i>Coronary Occlusion</i>
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		
DUE TO		
(c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21. I certify that I attended the deceased from alive on 4/9 , 19 52 , and that death occurred at 3:10 P.M. from the causes and on the date stated above.	ADDRESS (Street, city or town, state) 486 N Centre St.	DATE SIGNED 4/8/52
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ACTUAL SIGNATURE <i>Leo H. Ley, Jr.</i>	M.D.	PHYSICIAN'S NAME (Type) Leo H. Ley, Jr., M.D.	<i>Cumberland Ind.</i>
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22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF Apr. 11, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Mt. Tabor Cemetery	22d. LOCATION (City, town, or county) Spring Gal., Md.
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23. FUNERAL DIRECTOR'S SIGNATURE <i>James F. Scamelli</i>	ADDRESS Cumberland, Md.	24a. REC'D BY REGISTRAR April 9, 1956	24b. REGISTRAR'S SIGNATURE W. Frank, M. D.
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

SECRET//SI//REL TO DEMOCRATIC STABILIZATION

VII

Digitized by srujanika@gmail.com

2000 ~~XXV~~ XXV

BUREAU V.

APR 10 1956

REGEIV ED

INSTRUCTIONS

1
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Item 21 Film G196 5-7-56 ams MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03507

The bottom copy may be retained by the hospital or attending physician.

CERTIFICATE OF DEATH

3546

Reg. Dist. No. 6

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY Allegany MARYLAND		STATE West Virginia COUNTY Mineral	
CITY (If outside corporate limits, write RURAL OR end give nearest town) TOWN Westernport		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Keyser	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 503 Maryland Avenue		STREET ADDRESS (If rural give location) Route #2	
3. NAME OF DECEASED (Type or Print) Frances Eve Parrill		4. DATE (Month) (Day) (Year) OF DEATH April 26, 1956	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH Nov. 14, 1878
9. AGE last birthday 77 yrs.	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Mineral Co., W. Va.	12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME George W. Stagg	14. MOTHER'S MAIDEN NAME Sarah Ravenscroft		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no	16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS Mrs. Lee Maphis, Westernport, Md.	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
904.0 IMMEDIATE CAUSE (A) <i>Arthritis</i> ANTECEDENT CAUSE(S) DUE TO <i>Fried. Hip</i> DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <i>Home</i>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR? <i>Trying to get from bed to bath room.</i>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22. I hereby certify that I attended the deceased from <i>4-25</i> 1956, to <i>4-26</i> 1956, that I last saw the deceased alive on <i>4-25</i> 1956, and that death occurred at <i>4-15A.M.</i> from the causes and on the date stated above. SIGNATURE <i>R. C. Kelly</i> M.D.			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF <i>4-28-56</i> NAME OF CEMETERY OR CREMATORIAL <i>Cabin Run</i>	
24. REC'D BY REGISTRAR DATE <i>4-27-56</i>		REGISTRAR'S SIGNATURE <i>Mrs. Jean C. Kelly</i>	
25. FUNERAL DIRECTOR'S SIGNATURE Rogers Funeral Home Keyser, W. Va.		ADDRESS	

DEPARTMENT OF JUSTICE - BUREAU OF INVESTIGATION

SEARCH STATION OF DEATH

SEARCHED

SEARCHED - INDEXED - SERIALIZED - FILED

SEARCHED - INDEXED - SERIALIZED - FILED

1

SEARCHED - INDEXED - SERIALIZED - FILED

BUREAU V. S

APR 30 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

3521

CERTIFICATE OF DEATH

035084

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 17 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 6 WEST THIRD STREET	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 6 WEST THIRD STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print)		First FRANK	Middle	Last PIROLOZZI	4. DATE OF DEATH APRIL 10	Month	Day	Year 19 56
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH AUG. 21 1912	9. AGE (In years last birthday) 43 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE Labor	10b. KIND OF BUSINESS OR INDUSTRY Odd Jobs	11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD	12. CITIZEN OF WHAT COUNTRY? U S A
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13. FATHER'S NAME BENEDOTTO PIROLOZZI	14. MOTHER'S MAIDEN NAME CLEMENTINE DI CIZZO
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15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
			MEMORIAL HOSPITAL, CUMBERLAND, MD.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	PULMONARY HEART DISEASE	INTERVAL BETWEEN ONSET AND DEATH 10 Y
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 003 X	(b) PULMONARY FIBROSIS & EMPHYSEMA 30 Y	
	(c) PULMONARY TUBERCULOSIS - BILAT 2	

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
Acute CIRRHOSIS OF THE LIVER 1YR		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 1	20f. (City or town) 1	(County)	(State)
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21. I certify that I attended the deceased from 1949 , to 10 APR 1956 , that I last saw the deceased alive on 9 APR 1956 , and that death occurred at 6 A M , from the causes and on the date stated above.	ADDRESS (Street, city or town, state) 59 GREENE ST	DATE SIGNED 10 APR 56
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ACTUAL SIGNATURE ABellersman	M.D.	59 GREENE ST	CUMBERLAND MD.
PHYSICIAN'S NAME (Type)			

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4-13-56	22c. NAME OF CEMETERY OR CREMATORIAL St. Marys Cem.	22d. LOCATION (City, town, or county) Cumberland, Md.	(State)
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23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarnelli, Cumberland, Md.	ADDRESS	24a. REC'D BY REGISTRAR April 13, 1956	24b. REGISTRAR'S SIGNATURE W. F. Tracy, M.D.
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STATE OF UTAH

APR 12 1956

SEARCHED INDEXED SERIALIZED FILED

BUREAU V. S.

APR 12 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03510

3547

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 43 Westernport		c. LENGTH OF STAY IN 1b 19 Yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 404 Walnut St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Westernport	
3. NAME OF DECEASED (Type or print) Arrilda		First Fern	Middle Rogers
4. DATE OF DEATH April		Month	1956 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 24, 1903
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Joseph L. Wysell	
14. MOTHER'S MAIDEN NAME Hattie Weyand		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Dorsey Rogers	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Coronary artery disease (c)		INTERVAL BETWEEN ONSET AND DEATH 20 minutes 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>53</u> , to <u>April 25, 1956</u> , that I last saw the deceased alive on <u>April 25</u> , 19 <u>56</u> , and that death occurred at <u>4:00 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 20 Green St Piedmont W. Va.	
ACTUAL SIGNATURE <u>J. H. Wolverton Jr., M.D.</u>		DATE SIGNED	
PHYSICIAN'S NAME (Type)		22. BURIAL, CREMATION, REMOVAL (Specify) Burial	
23. FUNERAL DIRECTOR'S SIGNATURE C. L. Kelly		22b. DATE THEREOF April 28, 1956	22c. NAME OF CEMETERY OR CREMATORIAL Philos Cem.
23. FUNERAL DIRECTOR'S SIGNATURE C. L. Kelly		22d. LOCATION (City, town, or county) Westernport	(State) Md.
24a. REC'D BY REGISTRAR DATE 4-28-56		24b. REGISTRAR'S SIGNATURE Mrs. Jean C. Kelly	

BUREAU V. 4
APR 30 1956
MECELVFO

BUREAU V. 4
APR 30 1956
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-15 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18**03511****3557 CERTIFICATE OF DEATH**Reg. Dist. No. *4*

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY Allegany		MARYLAND		STATE Maryland COUNTY Allegany	
CITY (If outside corporate limits, write RURAL or TOWN and give nearest town) Route # 220 near Dawson, Md.		LENGTH OF STAY (in this place) 8 yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) Rural R #3 Keyser, W. Va.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS P. O. Address R 3 Keyser, W. Va.		STREET ADDRESS Route #220 near Dawson, Md.		(If rural give location)	
3. NAME OF DECEASED (Type or Print) Ezra			4. DATE OF DEATH (Month) April (Day) 10 , (Year) 1956		
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH March 7, 1882	9. AGE last birthday 74 yrs.	IF UNDER 1 YEAR Months 0 Dey 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer			10b. KIND OF BUSINESS OR INDUSTRY Own Farm	11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James Savage			14. MOTHER'S MAIDEN NAME Fannie Dedrick		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. 215-14-6484		
17. INFORMANT & ADDRESS Elwood Carskadon, R #3 Keyser, W. Va.			18. MEDICAL CERTIFICATION		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			IMMEDIATE CAUSE (A) <i>Coronary Occlusion</i> ANTECEDENT CAUSE(S) DUE TO (B) <i>Arteriosclerosis</i> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATEMENT UNDERLYING CAUSE LAST. DUE TO (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <input type="checkbox"/> (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) 486 N. Centre St. Cumberland (County) 41101 (State) 1956	
21d. TIME OF INJURY (Month) 3/26 (Day) 1956 (Year) 1956 (Hour) 9:45 P.M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 3/26 , 19 56 , to 4/10 , 19 56 , that I last saw the deceased alive on 4/12 , 19 56 , and that death occurred at 9:45 P.M. from the causes and on the date stated above.					
SIGNATURE <i>Levi D. Keyser</i> ADDRESS (Street, city, town, state) 486 N. Centre St. Cumberland DATE SIGNED 4/12/56					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4/13/1956		NAME OF CEMETERY OR CREMATORIAL Pleasant Valley Cemetery, Garrett Co., Md.	
24. REC'D BY REGISTRAR April 12, 1956		REGISTRAR'S SIGNATURE Winter R. Gandy, M.D.		LOCATION (City, town, or county) Oakland, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS			

RECEIPT OF DEATH

RECEIVED IN THE DEPARTMENT OF STATE

APR 13 1956

RECEIVED IN THE DEPARTMENT OF STATE

APR 13 1956

RECEIVED IN THE DEPARTMENT OF STATE

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RECEIVED IN THE DEPARTMENT OF STATE

APR 13 1956

BUREAU V. S

APR 13 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3523 CERTIFICATE OF DEATH

Reg. Dist. No. 4

03512

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, Md.		c. LENGTH OF STAY IN 1b 14 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland Md.		d. STREET ADDRESS 402 Grand Ave.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 402 Grand Ave.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Hattie		First	Middle	Last	4. DATE OF DEATH April 27,	Month	Doy	Year 1956
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1869		9. AGE (In years lost birthday) 86	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Ownhome		11. BIRTHPLACE (State or foreign country) Hay, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Daniel Wolford		14. MOTHER'S MAIDEN NAME Elizabeth Henderson						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Eldridge P. Saville 402 Grand Ave.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		19. INTERVAL BETWEEN ONSET AND DEATH						
(b) DUE TO cause (b), stating the under- lying cause last.								
(c) DUE TO cause (c), stating the under- lying cause last.								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Salem, W.Va.		(County) (State)
21. I certify that I attended the deceased from <u>Apr. 26</u> , 1956, to <u>Apr. 27</u> , 1956, that I last saw the deceased alive on <u>Apr. 27</u> , 1956, and that death occurred at <u>8:35 P.M.</u> from the causes and on the date stated above.						ADDRESS (Street, city or town, state) Cumberland		DATE SIGNED 4/30/56
ACTUAL SIGNATURE <i>Clay E. Durrett</i>								
PHYSICIAN'S NAME (Type) Clay E. Durrett, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5-1-56		22c. NAME OF CEMETERY OR CREMATORIAL Salem Meth Cem.		22d. LOCATION (City, town, or county) Salem, W.Va.		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>James P. Schenck</i>		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR Date Apr. 30, 1956		24b. REGISTRAR'S SIGNATURE <i>W.L. Frank, M.D.</i>		

May 1 1956

REFEIVED

Within corporate limits

To DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, write "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. To FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03513

Reg. Dist. No. 4

3524

1. PLACE OF DEATH
a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

17 years

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

D.O.A. at Memorial Hospital

3. NAME OF
DECEASED
(Type or print)

First
Harry James

Middle

Last

4. DATE
OF
DEATH

April

Day 25
Month 19
Year 56

5. SEX

male

6. COLOR OR RACE

white

7. MARRIED

NEVER MARRIED

8. DATE OF BIRTH

WIDOWED DIVORCED Jan. 3-1911

9. AGE (In years
last birthday)

45 yrs.

IF UNDER 1 YEAR

Months

IF UNDER 24 MRS.

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

Machinist

10b. KIND OF BUSINESS OR INDUSTRY

All. Ballistic Lab. Keyser, W. Va.

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Francis Marion Short

14. MOTHER'S MAIDEN NAME

Ada Pyles

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
(If yes, give war or dates of service)

no

16. SOCIAL SECURITY NO.

217-10-4661

17. INFORMANT

Address

daughter) Betty Lou Proud, Cumberland, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

420.1

Coronary (sclerosis) occlusion (left)

INTERVAL BETWEEN
ONSET AND DEATH
sudden

DUE TO

Conditions, if any, which
goe rise to immediate cause
(a), stating the underlying
cause lost.

(b)

Pulmonary edema

Terminal

DUE TO

(c)

Coronary Osteal occlusion (right)

?

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

19. WAS AUTOPSY
PERFORMED?
YES NO

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.

20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy , Inspection , Inquiry , and find that death resulted from: Natural causes , Accident , Suicide , Homicide , Undetermined cause .

ACTUAL
SIGNATURE

EXAMINER'S
NAME (Type)

H. V. Deming M.D.

M.D. CHIEF MEDICAL EXAMINER

ASSISTANT MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

DATE SIGNED

April 26-1956

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORIUM 22d. LOCATION (City, town, or county) (State)

Burial

April 28, 1956

Hillcrest Burial Park

Cumberland, Maryland.

23. FUNERAL DIRECTOR'S SIGNATURE

Charles L. George, Cumberland, Maryland.

ADDRESS

DATE

24a. REC'D BY REGISTRAR

DATE

24b. REGISTRAR'S SIGNATURE

DATE

DEPARTMENT OF HOMELAND SECURITY
FEDERAL BUREAU OF INVESTIGATION

BUREAU V. S.

APR 30 1956

REGELIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

3525

CERTIFICATE OF DEATH

Reg. Dist. No. 03514

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE W.VA.		b. COUNTY Mineral		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. LENGTH OF STAY IN 1b 3 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RIDGELEY				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL MEMORIAL & WARWICK AVES.,		d. STREET ADDRESS 18 PERRY ST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First ERNEST	Middle	Last SPRIGGS	4. DATE OF DEATH APRIL 19 1956	Month APRIL	Day 19	Year 1956	
S. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 8 1887	9. AGE (In years lost birthday) 68 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Boilermaker		10b. KIND OF BUSINESS OR INDUSTRY B.&O.R.R. Westernport, Maryland		11. BIRTHPLACE (State or foreign country) Westernport, Maryland		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME JOHN SPRIGGS		14. MOTHER'S MAIDEN NAME Augusta Ross						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-14-2333		17. INFORMANT Mrs. Mary Spriggs, Ridgeley, W. Va.		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x		DUE TO CEREBRAL THROMBOSIS		INTERVAL BETWEEN ONSET AND DEATH 1 month				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) DUE TO ARTERIOSCLEROSIS, General		5 years				
		(c) DUE TO COR PULMONALE, CHRONIC		10 yr				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Emphysema + Fibrosis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While <input type="checkbox"/> Not-while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)	20f. (City or town) 59 Greene St	(County) Cumberland	(State) Md.
21. I certify that I attended the deceased from _____, 19 ⁵⁰ , to 19 ⁵⁶ , that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 59 Greene St		DATE SIGNED APRIL 18, 1956		
ACTUAL SIGNATURE <i>S. G. Weisman</i>		M.D.						
PHYSICIAN'S NAME (Type) S. G. Weisman, M.D.								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 21 1956	22c. NAME OF CEMETERY OR CREMATORIAL Hillcrest Burial Park		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. H. Right</i>	ADDRESS Cumberland, Md.	24a. REC'D. BY REGISTRAR April 20, 1956		24b. REGISTRAR'S SIGNATURE W. H. Tracy, M.D.				

CERTIFICATE OF DEATH

NAME	SEX	AGE	DEATH DATE	TIME	PLACE	CAUSE
ROBERT L. HARRIS	MALE	35	APR 23 1956	11:30 A.M.	HOSPITAL	HEART DISEASE
BOSTON			MASSACHUSETTS			
APR 23 1956						

BUREAU V. S.

APR 23 1956

RECEIVED

may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3558 CERTIFICATE OF DEATH

03515
 Reg. Dist. No. 8

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD. b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. Marys Terrace		d. STREET ADDRESS St. Marys Terrace	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Anna	Middle Reid	Last Stakem
4. DATE OF DEATH	Month 4/25/1956	Month Year	Day Year 19
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb, 1st. 1868
9. AGE (In years last birthday) 82	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work	11. KIND OF BUSINESS OR INDUSTRY Own Home	12. BIRTHPLACE (State or foreign country) Lonaconing, MD.
13. CITIZEN OF WHAT COUNTRY? U.S.A.	14. MOTHER'S MAIDEN NAME Mary Sloan		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Mary Bonig, Lonaconing, MD. (Daughter)	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332X DUE TO Cerebral Thrombosis			INTERVAL BETWEEN ONSET AND DEATH 3d
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO Arteriosclerosis - Generalized (c)			10 y.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July , 19 52 , to 25 April , 19 56 , that I last saw the deceased alive on 25 April , 19 56 , and that death occurred at 12:00 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 51 Main Street, Lonaconing, MD.			
DATE SIGNED 4-26-56			
ACTUAL SIGNATURE George Eichhorn			
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 4/29/1956	22c. NAME OF CEMETERY OR CREMATORIAL Memorial Park	22d. LOCATION (City, town, or county) Frostburg, MD. (State)
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, MD.	24a. REC'D BY REGISTRAR DATE 4-27-56
			24b. REGISTRAR'S SIGNATURE Jeanette M. Bodd

BUREAU V.

APR 30 1956

RECEIVED
APR 30 1987

3526

CERTIFICATE OF DEATH

1. PLACE OF DEATH

a. COUNTY

Allegany

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

c. LENGTH OF STAY IN 1b

12/9/53

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Allegany County Infirmary

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

a. STATE

Maryland

b. COUNTY

Allegany

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Cumberland

02

d. STREET ADDRESS

214 Hay Street

e. IS RESIDENCE
ON A FARM?
YES NO 3. NAME OF
DECEASED
(Type or print)First
CharlesMiddle
R.Last
Steward4. DATE
OF
DEATH

April

Month
3
Day
19
Year
56

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

1/14/1906

9. AGE (In years
last birthday)
yrs.

50

IF UNDER 1 YEAR

Months
Days

IF UNDER 24 HRS.

Hours
Min.10a. USUAL OCCUPATION (Give kind of work done
during most of working life, even if retired)

None - handicapped as a child.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

Keyser, W. Va.

U. S. A.

13. FATHER'S NAME

William E. J. Steward

14. MOTHER'S MAIDEN NAME

Josephine Dawson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address P. O. Box 599

Allegany County Infirmary Records

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

592X

DUE TO

Conditions, if any, which
gave rise to immediate
cause (a), stating the under-
lying cause last.

(b)

DUE TO

(c)

Chronic Myocarditis.

INTERVAL BETWEEN
ONSET AND DEATH

48 hrs.

Chronic Nephritis.

?

Chronic Septatitis.

?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

Cerebral Edema?

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m.20d. INJURY OCCURRED
While at work Not while at work

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Dec. 9th, 1953, to Apr. 4th, 1956, that I last saw the deceased alive on Apr. 3rd, 1956, and that death occurred at 12:00 M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL
SIGNATURE

M.D.

49 Greene St.

4-4-56

PHYSICIAN'S
NAME (TYPE)

Dr. James E. McLean 49 Greene St., Cumberland, Md.

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)
(State)

Burial

April 6, 1956

Zion Memorial Park

Cumberland, Md.

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

24a. REC'D. BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

John J. Bafer, Cumberland, Md.

April 6, 1956

Dr. Frank, M.D.

UNITED STATES GOVERNMENT - DEPARTMENT OF JUSTICE

336

RECEIVED

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BUREAU U. S.

APR 9 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3527

CERTIFICATE OF DEATH

03517

Reg. Dist. No.

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If not done so, the certificate may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 Hr 20 Min		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Little Orleans		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Sacred Heart Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Baby	Middle Boy	4. DATE OF DEATH Swain -TWIN#1	Month April	Day 22	Year 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4/22/56	9. AGE (In years lost birthday) yrs. 1	10. IF UNDER 1 YEAR Months 1	11. IF UNDER 24 HRS. Days 20	12. IF UNDER 24 HRS. Hours 1
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME None				14. MOTHER'S MAIDEN NAME Novella N. Swain			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? [Yes or No or Unknown] None		16. SOCIAL SECURITY NO. None		17. INFORMANT Patient's Chart.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Insufficient Maturity of Vital Structures INTERVAL BETWEEN ONSET AND DEATH 81hr 20 min DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2 April , 1956, to 22 April , 1956, that I last saw the deceased alive on 22 April , 1956, and that death occurred at 601 Green St. , from the causes and on the date stated above. ACTUAL SIGNATURE Leland B. Ransom M.D. 1406 1/2 Green St., Cumberland, Md. 21421 DATE SIGNED 8:00 AM ADDRESS (Street, city or town, state)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 4/23/56		22b. DATE THEREOF 4/23/56		22c. NAME OF CEMETERY OR CREMATORIAL Allegany County Cemetery		22d. LOCATION (City, town, or County) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE W.M. Wright		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 24, 1956		24b. REGISTRAR'S SIGNATURE W.L. Frantz, M.D.	

RECEIVED - STATE DEPARTMENT - TELETYPE 100
1251 CERTIFICATE OF DEATH

RECEIVED
BUREAU V. S.

APR 25 1956

Within corporate limits
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3528

CERTIFICATE OF DEATH

03518

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY <u>Allegany</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Allegany</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>3 Hr. 40 Min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Little Orleans</u>		d. STREET ADDRESS <u>X</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>Baby Girl Swain</u>		First	Middle	Last	4. DATE OF DEATH <u>TWIN #2</u>	Month	Day	Year
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4/22/56</u>	9. AGE (In years last birthday) yrs. <u>1</u>	10. IF UNDER 1 YEAR Months <u>3</u>	11. IF UNDER 24 HRS. Days <u>10</u>	12. IF UNDER 24 HRS. Hours <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Novella Swain</u>				Address		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>None</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mother's Chart</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>759.0</u>		DUE TO <u>In sufficient maturity of vital structures</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3hr-10min</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>63 Greene St., Cumberland, Md.</u>		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <u>22 April</u> , 19 <u>56</u> , to <u>22 April</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>22 April</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> ADDRESS (Street, city or town, state) <u>63 Greene St., Cumberland, Md.</u> DATE SIGNED <u>5</u>								
ACTUAL SIGNATURE <u>Leland B. Ransom</u>		PHYSICIAN'S NAME (Type) <u>Leland B. Ransom, M.D.</u>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>4/24/56</u>		22c. NAME OF CEMETERY OR CREMATORIUM <u>Allegany County Cem., Cumberland, Md.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Right</u>		ADDRESS <u>Cumberland, Md.</u>		24a. REC'D BY REGISTRAR <u>W. H. Right</u>		24b. REGISTRAR'S SIGNATURE <u>W. H. Right, M.D.</u>		

RECEIVED
BUREAU V. A.

FR 5 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3529

CERTIFICATE OF DEATH

03519

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 45 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 628. Lincoln St		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Charles (Chuck) F.		d. STREET ADDRESS 628. Lincoln St	
4. DATE OF DEATH April 30, 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 27 1911
9. AGE (In years lost/birthday) 45 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tire Inspector		10b. KIND OF BUSINESS OR INDUSTRY Kelly-Springfield	
11. BIRTHPLACE (State or foreign country) Cumberland, Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Daniel A. Swarner		14. MOTHER'S MAIDEN NAME Agnes Irwin	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. II 217-09-4955	
17. INFORMANT Mr. Wm. Swarner, Cumberland, Maryland.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4343 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		Myocardial Exhaustion Cor pulmonale INTERVAL BETWEEN ONSET AND DEATH 4 months 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/29/56 19 to 4/30/56 19, that I last saw the deceased alive on 4/30/56 19, and that death occurred at <u>4pm</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Richard J. Williams, M.D.</u> ADDRESS (Street, city or town, state) <u>Cumberland, Md</u> DATE SIGNED <u>5/1/56</u> PHYSICIAN'S NAME (Type) <u>Richard J. Williams, M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 3, 1956	
22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Right</u>		24a. REC'D BY REGISTRAR Cumberland, Md May 2, 1956	
		24b. REGISTRAR'S SIGNATURE <u>W. F. Frantz, M.D.</u>	

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 4 1956

RECEIVED

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03520

3559 CERTIFICATE OF DEATH

Reg. Dist. No. 18

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN	Allegany Mt. Savage	MARYLAND LENGTH OF STAY (In this place) life	STATE Maryland CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mt. Savage
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
ANNA (BARTH)		UHL April 26, 1956	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed	8. DATE OF BIRTH 3-9-1871
9. AGE last birthday 85 yrs.	10. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Barth		14. MOTHER'S MAIDEN NAME Martha Bauer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY NO. none	17. INFORMANT & ADDRESS Clinton Uhl, Charleston, W. Va.	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443 IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO	Heart dilation and Hypertension Heart disease		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	Arteriosclerosis Senility		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION none	19b. MAJOR FINDINGS OF OPERATION		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21a. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from.....1950, to April 26, 1956, that I last saw the deceased alive on April 25, 1956, and that death occurred at 5 A.M. from the causes and on the date stated above.			
SIGNATURE <i>John G. Murray</i>		ADDRESS (Street, city, town, state) Cumberland	DATE SIGNED 1956
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 4-28-1956	NAME OF CEMETERY OR CREMATORIAL St. George Cemetery	LOCATION (City, town, or county) Mt. Savage, Md. (State)
24. REC'D BY REGISTRAR DATE 4-28-1956	REGISTRAR'S SIGNATURE <i>Veronica M. L. Lennett</i>	25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst, Frostburg, Md.	

BUREAU Y. S.

MAY 1 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-51 10W

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

03521

3548 CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH			2. USUAL RESIDENCE (HOME) OF DECEASED		
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN TOWN	Allegany Frostburg	MARYLAND LENGTH OF STAY (In this place) 4 hrs.	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TOWN	Maryland Frostburg	COUNTY Allegany (If rural give location)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Miners Hospital			STREET ADDRESS 166 W. Main St.		
3. NAME OF DECEASED (First) (Middle) (Last) FLORENCE (McKENZIE) WARNE			4. DATE (Month) (Day) (Year) OF DEATH April 5, 1956		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) married	8. DATE OF BIRTH 11-22-1894	9. AGE last birthday 61 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework			10b. KIND OF BUSINESS OR INDUSTRY own home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Cletus McKenzie			14. MOTHER'S MAIDEN NAME Martha Hetz		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. none		17. INFORMANT & ADDRESS Stanley Warne, Frostburg, Md.	
18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 331X IMMEDIATE CAUSE (A) <i>Cerebral Hemorrhage.</i> ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) <i>Hypertension</i> GIVING RISE TO THE ABOVE CAUSE DUE TO STATING UNDERLYING CAUSE LAST. (C) INTERVAL BETWEEN ONSET AND DEATH <i>14 hrs several years</i>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>April 5, 1956</i> , to <i>April 5, 1956</i> , that I last saw the deceased alive on <i>April 5, 1956</i> , and that death occurred at <i>11:00 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>Stanley N. Rae</i> ADDRESS (Street, city, town, state) <i>Frostburg, Md.</i> DATE SIGNED <i>4-8-56</i>					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 4-5-1956		NAME OF CEMETERY OR CREMATORIAL St. Anne's Cemetery Avilton, Md.	
24. REC'D BY REGISTRAR DATE 4-5-56		REGISTRAR'S SIGNATURE <i>Stanley N. Rae</i>		LOCATION (City, town, or county) (State) Frostburg, Md.	
25. FUNERAL DIRECTOR'S SIGNATURE J. R. Durst,				ADDRESS	

BY REQUEST OF THE STATE OF NEW YORK

STANDARD OF DEATH

ON AND AFTER

RECEIVED TO DEATH

BY THE STATE

STANDARD OF DEATH

BY THE STATE

RECEIVED TO DEATH

BY THE STATE

RECEIVED

APR 16 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3530 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03522

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 10 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. at Sacred Heart Hospital.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF -DECEASED (Type or print)	First Jack	Middle Frank	Last West		
4. DATE OF DEATH	Month April	Day 18	Year 1956		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 19-1905		
9. AGE (In years last birthday) 51	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur & laborer	11. KIND OF BUSINESS OR INDUSTRY C.Cement & Supply-Pittsburg, Pa.	12. BIRTHPLACE (State or foreign country) U.S.A.		
13. FATHER'S NAME Micheal Laminsky	14. MOTHER'S MAIDEN NAME Katie (Unknown)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 227-12-6960	17. INFORMANT (wife) Ruby Virginia West, Cumberland, Md.	Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombous INTERVAL BETWEEN ONSET AND DEATH sudden					
420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary sclerosis (right) several years					
DUE TO (b) Pulmonary edema					
DUE TO (c) Cardiac hypertrophy (moderate)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> 19. WAS AUTOPSY CAUSE OF DEATH. PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED April 18-1956
EXAMINER'S NAME (Type) H.V. Deming M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF April 21, 1956	22c. NAME OF CEMETERY OR CREMATORIUM Porter Cemetery	22d. LOCATION (City, town, or county) near Hyndman, Pennsylvania.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Hafer Funeral Home, Cumberland, Maryland.	ADDRESS Hafer	24a. REC'D. BY REGISTRAR Apr 19, 1956	24b. REGISTRAR'S SIGNATURE W.L. Frank, M.D.		

BUREAU V. S.

APR 20 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3531

CERTIFICATE OF DEATH

03523

Reg. Dist. No. 4

Within corporate limits

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland		c. LENGTH OF STAY IN 1b 1 year	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 Cumberland St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) Edward M. Wildes		First Middle Last 3rd	4. DATE OF DEATH Apr. 12 1956
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 5, 1952
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.
13. FATHER'S NAME Edward M. Wildes		14. MOTHER'S MAIDEN NAME Nancy Walsh	12. CITIZEN OF WHAT COUNTRY? USA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Edward M. Wildes, Cumberland, Md. Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 293.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Kern icterus secondary to hemolytic anemia			
INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
(b) DUE TO Kern icterus secondary to hemolytic anemia		3 yrs	
(c) DUE TO Inanition		2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED White Nat white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>March</u> , 1956, to <u>April</u> , 1956, that I last saw the deceased alive on <u>April 9, 1956</u> , and that death occurred at <u>8:15AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>John C. Devers</u> M.D. ADDRESS (Street, city or town, state) <u>Frostburg, Md.</u> DATE SIGNED <u>April 13, 1956</u>			
PHYSICIAN'S NAME (Type) John C. Devers		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF Apr. 14, 1956		22c. NAME OF CEMETERY OR CREMATORIAL Sacred Heart	22d. LOCATION (City, town, or county) Plains, Pa. (State)
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE <u>April 13, 1956</u>
			24b. REGISTRAR'S SIGNATURE <u>W. R. Hantz, M.D.</u>

CERTIFICATE OF DEATH

3291

HAMILTON

BUREAU Y. S.

APR 13 1956

RECEIVED

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13524

3532

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY Allegany		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 Cumberland		c. LENGTH OF STAY IN 1b 5 Months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100. Mullen Street		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland	
3. NAME OF DECEASED (Type or print) First Jackqelena		d. STREET ADDRESS 100. Mullen Street	
4. DATE OF DEATH Last Willis		Month April	Day 25 Year 1956
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 17 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own House	
11. BIRTHPLACE (State or foreign country) Grafton, W.Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Woodyard		14. MOTHER'S MAIDEN NAME Anna Barbee	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. W.L.Ranck, Cumberland, Ma.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 yrs - 70 days 70 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White Nat white of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 17, 1956</u> to <u>April 25, 1956</u> that I last saw the deceased alive on <u>April 25, 1956</u> , and that death occurred at <u>11:30 A.M.</u> from the causes and on the date stated above. ACTUAL SIGNATURE <u>C.M. Matthews M.D.</u> PHYSICIAN'S NAME (Type) <u>W.B. Matthews M.D.</u>		ADDRESS (Street, city or town, state) M.D. <u>44 Green St</u> DATE SIGNED <u>4/25/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 28/56	
22c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		22d. LOCATION (City, town, or county) (State) Newark, Ohio	
23. FUNERAL DIRECTOR'S SIGNATURE <u>An H. Right.</u>		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR DATE April 26, 1956		24b. REGISTRAR'S SIGNATURE <u>W.R. Frank, M.D.</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

APR 27 1956

APR 27 1981

DR. W.F. WILLIAMS 3533

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH a. COUNTY ALLEGANY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND	
3. NAME OF DECEASED (Type or print) First ANN Middle GERTRUDE Last WILSON		d. STREET ADDRESS 430 COLUMBIA STREET	
4. DATE OF DEATH Month APRIL Day 19 Year 1956		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH SEPT. 1, 1906
9. AGE (In years lost birthday) 49 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0	11. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress at home - Sewing for individuals		10b. KIND OF BUSINESS OR INDUSTRY CUMBERLAND, MD.	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME G. EMORY WILSON		14. MOTHER'S MAIDEN NAME ELIZABETH SCHRIVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 215-20-5966	
17. INFORMANT MEMORIAL HOSPITAL - CUMBERLAND, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetic Nephritis (uremia)		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) Diabetes Mellitus			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-17-1956 to 4-19-1956 that I last saw the deceased alive on 4-19-1956 , and that death occurred at 11:40 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Cumberland	
ACTUAL SIGNATURE W. F. Williams, M.D.		DATE SIGNED 4-20-56	
PHYSICIAN'S NAME (Type) W. F. Williams, M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 4/23/56		22c. NAME OF CEMETERY OR CREMATORIAL St. Peter & Paul	
22d. LOCATION (City, town or county) Cumberland		(State) MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Louis Stein Inc. Cumb. M.D.		24a. REC'D BY REGISTRAR April 23, 1956	
ADDRESS Louis Stein Inc. Cumb. M.D.		24b. REGISTRAR'S SIGNATURE W. F. Frantz, M.D.	

BY JONATHAN STUART TO THE EDITOR OF THE GUARDIAN

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RECEIVE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03526

DR. SIMONS

3534

CERTIFICATE OF DEATH

Reg. Dist. No. 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 02 CUMBERLAND		c. LENGTH OF STAY IN 1b 92 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near CUMBERLAND, rural		d. STREET ADDRESS RT. #2, BALTIMORE PIKE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 60 MEMORIAL HOSPITAL				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
3. NAME OF DECEASED (Type or print) M. Margaret AMANDA		First M.	Middle argaret	Lost WILSON	4. DATE OF DEATH APRIL 23 1956	Month APRIL	Day 23	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 29 1907	9. AGE (In years lost birthday) 49	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME GEORGE C. GROSS		14. MOTHER'S MAIDEN NAME AMELIA RICE						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT MEMORIAL HOSPITAL		Address MEMORIAL AVENUE		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Spine + lungs</i> INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>								
199.6 DUE TO								
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)								
DUE TO								
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)								
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Doy 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Cumberland	(County) Md.	(State) Md.
21. I certify that I attended the deceased from <i>Sept 1955</i> , to <i>4/23 1956</i> , that I last saw the deceased alive on <i>4/23 1956</i> , and that death occurred at <i>12:20A M</i> , from the causes and on the date stated above.								
ADDRESS (Street, city or town, state) <i>M.D. 128 Union St, Cumberland, Md.</i> DATE SIGNED <i>4/24/56</i>								
ACTUAL SIGNATURE <i>George M. Simons</i>								
PHYSICIAN'S NAME (Type) <i>M.D.</i>								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/25/56		22c. NAME OF CEMETERY OR CREMATORIUM Mt Pleasant Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 25, 1956		24b. REGISTRAR'S SIGNATURE Wm. R. Tracy, M.D.		

CERTIFICATE OF DEATH

5-10-50

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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RECEIVED
APR 27 1956

Within corporate limits
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, striking the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3535 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03527
4

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)	
Allegany		a. STATE Md.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY Allegany	
Cumberland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
50 years		Cumberland	
c. LENGTH OF STAY IN 1b		d. STREET ADDRESS	
50 years		105 South George St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
105 South George St.		105 South George St.	
3. NAME OF DECEASED (Type or print)		First	Middle
Fred		W.	Wiltison
4. DATE OF DEATH		Month	Day
April 15		Year	1956
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
male		white	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH		9. AGE (In years last birthday)	10. IF UNDER 1 YEAR Months Days Hours Min.
Feb. 17-1873		83 yrs.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
Retired Painter		Springfield, Ohio	
12. CITIZEN OF WHAT COUNTRY?		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Edmond Wiltison		Clara Matchell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
no		215-26-9753 (brother) James Wiltison, Burlington, W. Va.	
17. INFORMANT		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
976X		Intracranial hemorrhage	
DUE TO		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		sudden	
(b)		a 32 caliber revolver wound in right	
DUE TO			
(c)		temporal region. (Self inflicted)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
Shot himself with a 32 caliber revolver.			
20c. TIME OF INJURY Month, Day, Year Hour <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> 6 p.m. 4-15 1956		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Home		Cumberland Allegany Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>		DATE SIGNED	
ACTUAL SIGNATURE <i>H.V. Deming M.D.</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) H.V. Deming M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/> April 16-1956	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-19-1956	
22c. NAME OF CEMETERY OR CREMATORIAL Burlington Cem.		22d. LOCATION (City, town, or county) (State) Burlington, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Charles L. George		ADDRESS Cumberland, Md.	
24a. REC'D BY REGISTRAR April 18, 1956 W.L. Frantz M.D.		24b. REGISTRAR'S SIGNATURE	
VS. A15ME(5) 5M 9/55			

MASSACHUSETTS STATE GOVERNMENT OF MASSACHUSETTS
3332 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
APR 20 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Within corporate limits

DR. JACOBSON

3536

CERTIFICATE OF DEATH

03528

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ALLEGANY		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7HRS. 40 MINS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		d. STREET ADDRESS 612 MONTGOMERY AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL				d. STREET ADDRESS 612 MONTGOMERY AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARTHA	Middle F.	Last WITHERUP	4. DATE OF DEATH APRIL 9, 1956	Month APRIL	Day 9	Year 1956
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	8. DATE OF BIRTH OCT. 29, 1893	9. AGE (In years lost birthday) 62 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ex. Secy. American Red Cross		10b. KIND OF BUSINESS OR INDUSTRY MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVE.		11. BIRTHPLACE (State or foreign country) OHIO		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JAMES O'DONNELL		14. MOTHER'S MAIDEN NAME ANN WHITE		Address			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-03-7106		17. INFORMANT MEMORIAL HOSPITAL-WARWICK & MEMORIAL AVE.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute left Ventricular Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Acute Anterior Myocardial Infarction DUE TO (c) Coronary Thrombosis	
						INTERVAL BETWEEN ONSET AND DEATH instant	
						12 hours	
						12 hours	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from April 9, 1956 to April 9, 1956 that I last saw the deceased alive on April 9, 1956 , and that death occurred at 4:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 50 Pershing Street, Cumberland, Maryland		DATE SIGNED 4-9-56					
ACTUAL SIGNATURE <i>Samuel Jacobson</i>		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial					
22b. DATE THEREOF 4/12/56		22c. NAME OF CEMETERY OR CREMATORIUM Hillcrest Cemetery		22d. LOCATION (City, town, or county) Cumberland, Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. Lee Silcox		ADDRESS Cumberland, Md.		24a. REC'D BY REGISTRAR April 12, 1956		24b. REGISTRAR'S SIGNATURE W. Frank, M.D.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the physician or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WILSON STATE DIVISION OF DEATH - BALTIMORE, MD

CERTIFICATE OF DEATH

NAME

BUREAU V.

APR 12 1956

RECEIVED